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Journal of Social Hygiene

New Year's Number

CONTENTS

How Far Have We Come? How Far Have We to Go? A New Year's Message to Association Members and Friends ..... Philip R. Mather 1

The Association's Annual Meeting 6

Psychiatric Factors in Social Hygiene Problems:

Editorial 7

Social Hygiene—A Psychiatric Viewpoint ..... Brian Bird 9

A Psychiatric Approach to the Treatment of Promiscuity: Excerpts from a forthcoming report from the San Francisco Psychiatric Clinic ..... Benno Safier, et al 20

The Venereal Disease Patient as a Delinquent ..... Leslie E. Luehrs 26

National Events ..... Eleanor Shenehon 34

News from the States and Communities ..... Esther Emerson Sweeney .. 40

World News and Views ..... Jean B. Pinney and Josephine V. Tuller 43

Announcements 48

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Wednesday, February 2, 1949

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Journal
of
Social Hygiene

VOL. 35 JANUARY, 1949 NO. 1

HOW FAR HAVE WE COME? HOW FAR HAVE WE TO GO?

A New Year's Message from President Mather

The American Social Hygiene Association finished up thirty-five years of work in 1948. Through times of crisis—two World Wars, a major economic depression, and frequent minor emergencies—and through times of peace and normal prosperity, the Association has served as the national leadership agency heading up citizen interest and action towards the goals set by the organization's founders in 1913. The broad objective has been—and still is—to protect and strengthen American family life as "the basic social unit" and the nation's most valuable asset. The drive towards this objective has two specific aims: First to build personal and family stability through the right use of sex in life. Second, to prevent and repair health and character damage which may result from the wrong use of sex. To these ends, the Association's working program, known throughout the world as "the four-fold American plan," calls for continuous balanced endeavor to promote sound family life education, to stamp out the venereal diseases, to smash the commercialized prostitution racket and help its victims start life anew, and to build citizen knowledge and opinion for effective State and community action in all these matters.

How does this four-fold program work? What has it achieved? As this thirty-sixth ASHA year begins, let's go back to 1913 for a "then-and-now" look at the record.

The Campaign Against Venereal Diseases

In 1913	In 1949
Few reputable physicians could or would treat patients infected with syphilis or gonorrhea. Few medical schools trained students for this difficult and highly specialized field of medicine.	VD diagnosis and treatment have become routine general practice. Schools of medicine and public health as a rule provide special and thorough training.
VD quacks and other illegal practitioners flourished in large numbers, unrestrained by business ethics or public health law. Drug-stores sold VD nostrums and prescribed treatment "over the counter."	Cooperative efforts of ASHA and ethical business and professional organizations, including pharmacists, plus public education, penicillin, and good state laws, have put most of the quacks out of business.
The U. S. Public Health Service had no program and no funds to attack VD. Most State and City health departments were in like circumstances. There was no general citizen understanding or interest in the need for such a program.	The National Venereal Disease Control Act passed by Congress in 1938 in response to citizen demand led by ASHA provides generous Federal appropriations for VD prevention and control.
VD Clinics, few in number and scanty in staff and facilities, treated only indigent patients. Most hospitals would not receive VD infected patients.	Sixty Rapid Treatment Centers and 3,000 clinics receive and treat patients from all walks of life. Nearly all hospitals accept VD patients.
Syphilis blood tests for brides and grooms before marriage, and for expectant mothers before the birth of babies, were largely unheard of.	Three-fourths of the States help to protect marriage and babies from syphilis by laws requiring premarital and prenatal examinations.
The people, because of taboos against public discussion of VD, had little knowledge of its dangers to health and happiness, nor knew what to do if infection occurred.	Newspapers, magazines, radio and motion pictures provide frank, accurate and widespread information regarding syphilis and gonorrhea.

The Attack on Commercialized Prostitution

In 1913	In 1949
Prostitution was considered, even by some well-informed and intelligent people, as a "necessary social evil," which by "concentrating vice" actually protected the rest of the community from VD and immorality.	Most citizens know that prostitution, while still "evil", is anti-social and entirely unnecessary; that it does not protect health or morals; that it is, in fact, a sordid, wholly commercial "business" in which the "big money" goes to the vice racketeers.
Many cities and towns, while in most respects maintaining law and order and good environment for family life, frankly tolerated "red-light districts."	Forty-six states have adequate laws to protect community and family life against prostitution. In only a few cities in one State in the USA is prostitution legally approved.
Young women—and some young men—who had become involved and victimized by prostitution were considered to have sunk to a level below the possibility of recovery.	It is generally accepted that most such young victims, by careful counsel and improved environment, can be guided back to a better way of life.

There was little planned effort to prevent such personal catastrophe by education or environmental protection.

Today a planned program, through juvenile courts, probation workers, trained policemen and women and other protective workers, safeguards youth in most communities.

Education for Family Life

In 1913

Few parents believed it necessary to tell their children the "facts of life," or tried to learn how to do this.

Practically no schools undertook to provide instruction in social hygiene education, except as physicians were called in to give what were often known by their young hearers as "smut talks" or "horror lectures."

Few pastors and church workers had the training or skills to meet their opportunity and responsibility for marriage guidance and family life counseling and education.

Young people themselves, though then as now much interested in such matters, sheered off from open group discussion of marriage education and related problems.

In 1949

Most parents are sincerely anxious to teach their children what they should know of the meaning of sex in life, and seek information and guidance for themselves for this purpose.

Nearly all schools teach some basic social hygiene in home economics or physical education courses, and an increasing number of schools, through courses in human relations, biology, and physiology, are providing specific instruction.

Today, all sects consider such work an important part of pastoral and parish duties, pastors and church leaders are well equipped in this respect and many are helping to train others.

Institutes, forums and group discussions on dating, marriage and the family are among the most popular and vital events on the college campus and among youth groups generally.

Public Information and Community Action

In 1913

It was generally considered that "nice people don't talk about VD—nice people don't have VD."

Few, even among informed and intelligent professional workers, realized the interrelationship among social hygiene problems—that one frequently stems from another.

Public opinion was largely uninformed and indifferent regarding community social hygiene conditions and the need to take action to improve them.

There were eleven voluntary state and community social hygiene societies—the first one formed in 1904.

The ASHA, with a modest headquarters office in New York, and a small staff of young and untried workers, tackled the nation's huge social hygiene problem, without benefit of previous tradition or experience on which to base efforts. The group of dis-

In 1949

It is generally understood that VD is no respecter of wealth, breeding or education.

All professional workers, and most lay citizens, know that vice spreads VD, that VD is not only a health problem, but often a symptom of lax morals; that the attack must be on all fronts at once.

Public opinion is informed, concerned and vigorous in support of community social hygiene action.

There are 250 state and local societies, committees and other voluntary citizen groups.

Today the ASHA program is implemented by thirty-five years of experience, a trained professional staff, a well-equipped headquarters and regional offices across the country, a membership of 20,000 and the cooperation of many other national agen-

tinguished leaders who founded the movement and the few hundred progressive men and women who made up its membership were its only important assets.

cies, including many Federal bodies and several hundred national voluntary organizations whose combined membership totals millions of informed and active persons and groups.

This, even the most skeptical will agree, is progress. Progress which can be measured in terms of better homes, better health, better communities, a stronger United States of America. And like any other kind of real progress towards a chosen goal, it didn't "just happen" . . .

> . . . The great gains against the venereal diseases, which can be total victory if we fight with all the weapons at our command . . .
>
> . . . the vigorous nation-wide crackdown on commercialized prostitution . . .
>
> . . . the growth of parent-school-church endeavor to give young people the right background and training for marriage and family life . . .
>
> . . . the informed public which now approves social hygiene efforts and backs up knowledge and understanding with effective action . . .

. . . all these in large measure are results of the working plan originated by the Association's founders, and fulfilled through the years by wise guidance, hard toil, and a talent for teamwork.

One advantage of this plan is the inter-relation of its four-fold parts, which in times of emergency or special opportunity, permits concentration on a needed aspect of work without slowing up the march towards the whole long-range goal. Thus, in World Wars I and II, while the Armed Forces asked for all-out ASHA effort to guard manpower from VD and prostitution, the educational program included in this effort opened the way for broad and greatly increased work of this kind when war was over. Today's wide interest and growing activity concerning education for family life is the modern counterpart of the movement which caught the minds of groups across the country in 1920, and to which the Association, then as now, gave national leadership and impetus.

Not only public knowledge of VD, but the whole social hygiene movement, has been advanced by the greatly expanded program of public education on syphilis and gonorrhea which the Association undertook in 1936 in cooperation with Surgeon General Parran in the renewed fight against VD. Through widespread annual observance of National Social Hygiene Day and continued year-round activities, this ASHA program has been largely responsible for the great growth of citizen interest and the citizen support which has resulted in adequate funds for the governmental campaign.

Again, in the summer of 1948, when the Association was asked to aid the Government's new National Defense program by special educational work and by marshalling community action to maintain wholesome conditions in the vicinity of defense establishments, this did not mean that

any part of the regular program would be put aside or reduced in scope. Rather, the ASHA long-range work, while furnishing background for this special project, is benefiting from the relationship in many ways.

Similarly, when in 1945 health and welfare leaders overseas asked the Association, as the leading social hygiene agency in the world's most prosperous and stable country, to pull together the broken threads for new international cooperation, the assignment of staff and facilities to work with the United Nations and with agencies and workers around the globe meant no diversion of interest or effort from social hygiene needs in the United States—but rather new strength for the ASHA program from hundreds of old and new friends in other countries.

From Here On . . .

What lies ahead? How far have we to go for final accomplishment of our broad objectives? Can the Association look forward in another decade, or another generation, or at any foreseeable time, to the achievement of that other goal of all voluntary effort—practical programs so well established and effectively maintained by governmental or other agencies that special stimulation and planning and leadership are no longer needed? To attempt an answer to this last question, viewed in the light of today's shifting scene, would require even greater wisdom and foresight than that of the founders! For the rest, it seems clear, if the gains so far made are to be held, that ASHA must provide for the immediate future:

Redoubled drive, by public education and community cooperation, to finish up the job of stamping out VD.
VD infections still remain the nation's greatest problem in communicable disease control,—still bring tragedy to far too many thousand American homes.

Constant alertness to the danger of a resurgence of commercialized prostitution, with prompt action when needed.
ASHA field studies for 1948 show 38 per cent of communities with "bad" prostitution conditions, as compared with 19 per cent a year ago, and 4 per cent at the beginning of 1946.

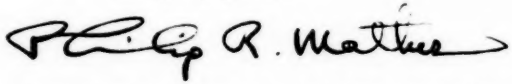
Expanded activities to utilize the growing eagerness of the public and of special groups, to join in the program for family life education.
Each new generation calls for new and up-to-date materials and methods for this purpose, while standard, well proved publications and projects must be continuously made more widely known and used.

No letup in the year-round campaign to keep the public informed of all these developments, and working as citizen leaders alongside professional social hygiene workers in well-planned, effective community programs. Every state, every community, needs a rounded, balanced social hygiene program for satisfactory progress in health and welfare.

The Association accepts this challenge with pride in the past, with faith and courage for the future, and in the confidence that all forward-looking men and women may be counted on to work with us. Your comments and suggestions regarding the national program will be appreciated. Any information you can give us about local social hygiene conditions, or ideas for needed activities will be gladly received. If you are not already an Association contributor or member your support in this way will be especially valued at this time, when many new demands are being made upon us for publications and other materials, as well as for staff advice and counsel. At all times, remember "We're at Your Service"!

May the New Year bring you and yours all the best things in life.

Faithfully yours,



President, American Social Hygiene Association

January, 1949

ANNUAL MEETING
AMERICAN SOCIAL HYGIENE ASSOCIATION

Important Notice to Members

The two sessions of the Thirty-sixth Annual Meeting of the American Social Hygiene Association will be held January 31, and February 2, 1949, as follows:

Monday—January 31, 1949—First Session

Room 1404, 1790 Broadway (at 58th Street) **New York City, N. Y.**

10:00 a.m. Annual Business Meeting of Association Members, election of Officers and Board Members and other business.

Wednesday—February 2, 1949—Second Session

Hotel Statler, Washington, D. C.

Annual Program Meeting and Regional Conference

In cooperation with the Social Hygiene Society of the District of Columbia

10:00 a.m. to 12:00 Noon Morning Session

The Character Guidance Programs of the Armed Forces, by officers of the Army, Navy, and Air Force.

12:30 p.m. to 3:00 p.m. Social Hygiene Day Luncheon Session:

Presiding: MR. PHILIP R. MATHER, *President*, American Social Hygiene Association.

Awards: William Freeman Snow Medal.
Honorary Life Memberships.

Addresses: THE HONORABLE FRANCES PAYNE BOLTON, M.C.
SURGEON GENERAL LEONARD A. SCHEELE, *United States Public Health Service*.

3:30 p.m. to 5:00 p.m. Afternoon Session: Panel discussion
Education for Marriage, Parenthood and Home-making.
Moderator: DEAN JAMES HAROLD FOX, George Washington University School of Education.

Details of the program will appear in later publications or will be sent on request. In the meantime advance suggestions and proposals regarding program, selection of officers, and administration of the Association's affairs may be submitted by members and will be referred to the appropriate standing committees and the Board of Directors for study and action.

All sessions of the Annual Meeting of the Association will be open to the public, and friends are invited to join the members in attendance on January 31st and February 2nd.

ROBERT P. FISCHELIS
Secretary
American Social Hygiene Association
1790 Broadway, New York 19, N. Y.

EDITORIAL

PSYCHIATRIC FACTORS IN SOCIAL HYGIENE PROBLEMS

The beginning of a new year is a good time to look at one's job objectively; to acquire perspective; to consider how related efforts may aid success of the particular endeavor, and vice versa. But that is only one reason why it seemed fitting to the JOURNAL's Editors that this first issue of 1949 should devote part of its space to the psychiatric aspects of social hygiene. Another good reason is the need to serve promptly and intelligently the growing interest and understanding among professional workers in all fields regarding the contribution which the skilled art of psychiatry may make to human health and welfare. But the JOURNAL publishes these articles chiefly at this time because they seem to us to be good, straightforward expositions of practical psychiatric methods in social hygiene work, as well as of the theories behind the methods. Dr. Luehrs' provocative discussion of *The Venereal Disease Patient as a Delinquent* is food for thought for all who are responsible for guiding and healing the VD infected. The brief excerpts from the forthcoming San Francisco report on *A Psychiatric Approach to the Treatment of Promiscuity*, while permitting only a glimpse of this dynamic project in action, indicate that its worth as a social hygiene rehabilitative aid has been demonstrated, and sharpen anticipation for the full story. Dr. Brian Bird's keen commentary on *Social Hygiene—A Psychiatric Viewpoint*—rounds out the over-all picture.

In a reminiscent mood in part invoked by the "then and now" comparison in the first pages of this JOURNAL, and reflecting on Dr. Bird's interesting grouping of the long-range objectives of social hygiene under the term "changing human sexual behavior"

we turned, as we often do, to the original statement of social hygiene aims, the Association's Constitution, drawn up in 1913 by those founders of the movement to whom this article pays such fine tribute. One of the briefest documents of the sort on record, this Constitution has only two Articles. *Article I* says: *The name of this Association shall be the American Social Hygiene Association. Article II* states: *The purposes of this Association shall be to acquire and diffuse knowledge of the established principles and practices and of any new methods, which promote or give assurance of promoting, social health; to advocate the highest standards of private and public morality; to suppress commercialized vice, to organize the defense of the community by every available means, educational, sanitary or legislative, against the diseases of vice; to conduct on request inquiries into the present condition of prostitution and the venereal diseases in American towns and cities; and to secure mutual acquaintance and sympathy and cooperation among the local societies for these or similar purposes.*

"Changing human sexual behavior" is indeed implied in these purposes, and the reader is once more impressed, as Dr. Bird says, with the broad vision of those first social hygiene planners, which enabled them to see this huge problem whole, and with the vigorous spirit which gave them the courage to tackle it.

Another leader, Dr. Ray Lyman Wilbur, has more recently given us some social hygiene words to live and work by. "The goal of social hygiene" he said in his Presidential message to Association members in 1945, as the nation turned from wartime efforts to peacetime plans, "is a people healthy, normal, well-balanced—fit to build successful families, homes, communities—as foundation-stones of national strength and progress. . . . I mean the broad, almost limitless concept of a people as a whole dedicated to getting the best from life on the uppermost planes of health, happiness and of general welfare. . . . How to live as persons, as partners in marriage, as parents, as members in a family structure stoutly built from within, strongly defended against attacks from without, and ready to serve in community and country. . . . This we must do, if the future of the family is to be safeguarded and the march continued towards the long-range goals of social hygiene . . ."

And now, in 1948, President Mather's questions asked on the masthead page of this issue of the JOURNAL may well be repeated here:

How far have we come on this march? A good distance, counting mile-stones of progress in terms of professional and public understanding and action, in terms of medical science's conquest of syphilis and gonorrhea, in terms of knowing more definitely where we are going and how to get there. How far have we to go? It is a long journey, to some extent beginning all over again with each generation. But we are on our way, and such thoughtful discussion as that in these articles both suggests new cooperative possibilities between two closely allied fields of work, and aids definitely in clearing the road ahead.

SOCIAL HYGIENE—A PSYCHIATRIC VIEWPOINT*

BRIAN BIRD, M.D.

Assistant Professor of Psychiatry, School of Medicine, Western Reserve University, Cleveland, Ohio

Social hygiene has two major aims—to prevent and cure those communicable diseases that are transmitted through sexual intercourse and to change human sexual behavior.

Both aims are vast, ambitious and exceedingly important. Both have resulted from bold, progressive thinking by leaders in many fields of community life. Those early leaders who formulated the aims of social hygiene were truly great, great in courage and in wisdom, for it was not easy to remove the lid of secrecy and shame from venereal disease; it was not easy to be rational where sexually transmitted diseases were concerned; nor was it easy to admit that sexual behavior should be changed. These acknowledgments, it must be remembered, represent revolutionary changes in public thinking, changes that might well have taken a hundred years to bring about; yet social hygiene leaders were at once so bold and so wise in their education of the public that these changes were brought about within a very few years.

Social hygiene, in view of its two major aims, has two major jobs to do. Today, with you, I want to look at those two jobs to see whether we can learn what each job really consists of, how big it is, and just how the two jobs are related.

The first aim and the first job of social hygiene is the prevention and cure of venereal disease. This job, as I see it, has several parts, all of which must be carried on simultaneously. Treatment of venereal disease is an essential, an immediate part of the job. Drugs that are known to be effective in treatment must be readily available to all; but drug therapy alone is not enough. Social casework must be part of treatment and its importance in the treatment of venereal disease cannot be minimized. All infected persons should be interviewed by caseworkers and most should be given service, the kind of case work service they need, service that includes psychiatric referral and consultation, promptly and adequately available psychiatric consultation and treatment. Moreover, all patients with repeat infections should automatically come to psychiatric attention.

Right along with treatment in the prevention and cure of venereal disease must go active social control. This means vigorous case finding—every contact followed up. It also means the compulsory reporting of all cases to a central bureau, especially compulsory

* An address given at a luncheon meeting arranged by the Joint Social Hygiene Committee, Academy of Medicine of Cleveland and Cleveland Health Council, on Social Hygiene Day, February 5, 1948.

reporting of cases by doctors, clinics and hospitals. Beyond question, it means forcing infected persons to take treatment. There must be, as well, an elimination of all public sources of contact: prostitution, improperly run bars, restaurants, clubs, dance halls. But with this must go provision for adequate recreational facilities to take the place of those eliminated.

Along with treatment and social control a net of prevention must be spread. Prevention demands mass surveys for the detection of syphilis. Prevention calls for group education in schools, churches, clubs, which will make it possible for people to learn about venereal disease, what it is, how it can be prevented, controlled, treated and cured. It also calls for broader public education through pamphlets, talks, newspaper, radio, films, and the regular and constant and emphatic presentation of facts, statistics, new discoveries, and general information.

The final part of this first job of social hygiene is the eradication of venereal disease. Responsibility for the eradication of venereal disease rests at present with research personnel, for syphilis and gonorrhea will only be eradicated when vaccines or other immunological preparations are discovered. This fact should not be forgotten but, at the same time, so long as we believe the eradication of venereal disease to be an ultimate aim of social hygiene, we must share that responsibility and must encourage and finance research workers and demand that they seek constantly for methods of conferring immunity to syphilis and gonorrhea on all people.

Those, very briefly, are some of the things that are involved in the first job of social hygiene, the job that aims at prevention and cure of venereal disease.

The second aim and the second job of social hygiene evolved out of the first. Very early in social hygiene history it was recognized that a great many venereal disease sufferers had remarkably little knowledge of sex and what knowledge they did have was often grossly distorted. It was naturally assumed, as a result of this discovery, that ignorance of sex and venereal disease had something to do with one another, and it was further assumed that if people only knew that venereal disease and sexual intercourse were related they would not have intercourse and thus would not catch venereal diseases.

The earliest sorties into sex education were therefore clearly and purposely part of the venereal disease prevention program and there was little or no thought given to the entire subject of sexual development. In those early days, sex education consisted almost wholly of telling high school children the facts of venereal disease and warning them that these diseases were the result of sexual intercourse. Very soon, however, it became apparent that there was much more to sex education than the passing out of such warnings.

It was found, in fact, that scaring children about venereal disease was about as harmful a thing to do as anyone could think of. Thereupon, people began experimenting to discover what it was children wanted to know about sex and to establish certain truths about sex that all children should know. Out of this developed a body of knowledge that is accurate, essential and great in scope. Planned sex education is now an accepted part of a child's general education. It starts ideally in infancy and is a continuous, unspectacular learning process that never ends. Sex education is no longer based on venereal disease information, and the teaching of facts about venereal disease rests where it should, in those school courses dealing with infectious diseases generally.

This, briefly, has been the course of evolution of social hygiene. At first there was one job, the prevention and cure of venereal disease; then, there were two closely related jobs, the prevention and cure of venereal disease and the beginning of definite sex education; now, there are these two jobs, two jobs which are separate and distinct although still strongly and dramatically related. The only real relationship, however, which now remains between the first and second jobs of social hygiene is the well-founded belief that a person whose sexual life is healthy will not expose himself to venereal disease. Improved sex education will, therefore, certainly reduce venereal disease, *but* . . . and this is the most important question confronting us today . . . *but* what other benefits besides less venereal disease will better sex education bring? Perhaps we shall find that many grave social and health problems can be prevented by insuring healthy sex development. If we do discover that other social and health problems can be prevented or reduced through attention to sex education we should then ask ourselves whether sex education is of even bigger concern than venereal disease; whether venereal disease authorities should be expected to shoulder the tremendous burden of sponsoring sex education; whether, in fact, other areas of health and welfare should not accept their proper share of this responsibility.

In order to discover how important good sex education is we should examine briefly the effects of inadequate sex education—the effects of sexual ignorance, misinformation, distortion and conflict. These effects can be found all around us; they can be found right within ourselves for none of us is free from conflicting ideas, prejudiced ideas, ignorant ideas about sex and all of these ideas affect our happiness and our success in life.

But although these effects are common enough in all of us, it is often impossible to acknowledge them or even see them. It is always much easier to see the effects of deficiencies in others. For this reason I will let you take a look at a few people I know, people I know well because I have treated them. Now I am sure some of you will say at this point that psychiatric patients are abnormal and such psychiatric findings, as derive from this study, should

not be applied to normal people like us, you and me. I offer no defense against such criticism except to say that outwardly a very great many of our psychiatric patients are perfectly normal and it may be that only the patient and the psychiatrist realize that the patient is emotionally ill at all. Also, a very great many of us who are not acknowledged psychiatric patients carry around with us, well covered, amply compensated, firmly embedded in our normal lives, problems identical in kind and in degree with the problems which are revealed under psychiatric study of others. Normal, our patients, in the great majority, do appear to be. Even the closest relatives of our psychiatric patients may insist and often do insist that the patient in question is quite normal and would be all right if he only used a little sense. After treatment has gone on some months and the patient begins to change, such relatives nod wisely and say they knew all along he would snap out of it—too bad he wasted his money on treatment.

But this admittedly is aside from the point. In any event a person is not normal just because he does not go to a psychiatrist and I believe we *can* learn something about the importance of sexual conflicts by hearing the stories of those who do.

A brilliant, attractive woman of twenty-three came to me, despondent and hopeless, saying that life was not worth living. Despite her intelligence and her good education, this woman knew practically nothing about sex. She did not even know the meaning of the word "masturbation." Yet, two weeks before coming to see me she had given birth to an illegitimate child.

A man of thirty-five came to me because of repeated outbursts of anxiety, followed in each case by a serious attack of drinking. His history was that as a boy he was devoted to his mother; as a young man he pleased his mother by taking no interest in young women; as a middle-aged man he discovered he was homosexual. Each homosexual episode drove him into a panic that could only be relieved by alcohol. He became an alcoholic.

A forty-year old professional woman came for help because she had lost confidence in herself and could no longer make decisions. She came from a home where sex was never mentioned and although she was curious she was never able to find out anything about sex. At the age of twenty she impulsively had intercourse and became pregnant. She obtained an abortion and avoided men from then on.

A girl of thirteen became panicky at the time of her first menstrual period. It was later learned she feared she had injured herself by masturbation.

A man came for help after his wife divorced him. He reported being incapable of having intercourse with his wife throughout almost their entire marriage. He was quite capable with other women.

A woman of forty, proceeding with a divorce, reported having a constant dread of sex. She said no one had ever told her anything about sex. She was six months pregnant with her first baby before she knew how it would be born.

A seventeen-year old girl asked me for psychiatric help. She was unhappy and confused, unable to hold a job or keep a boy friend. She hated her family and her family hated her. Until she was twelve years old this girl was a model child, devoted to her church, obedient to her parents and not at all interested in sex. From twelve to seventeen she became unbelievably promiscuous, had gonorrhea twice—she still had very little knowledge of sex.

These people are not crazy people. These people are your friends and my friends; they are, in fact, you and I. They all have problems, we all have problems that have their origin in sexual conflict and sexual misinformation. These people I have described would all have been much healthier and happier if in their childhood they had learned truthfully about sex. We would all be healthier and happier if we had not picked up such distorted ideas about sex.

Now let us examine the situation from another angle. Instead of examining individual people in trouble, let us review some of the major problems that arise in the fields of health and welfare to see what part is played in their causation by inadequate sex education.

Let us consider alcoholism. Alcohol causes alcoholism. But why do some people drink to excess while others do not? There are, of course, a hundred reasons why a person drinks too much but of all of these reasons the most constant finding is immature, unsatisfactory sexual behavior. Accordingly, a realistic approach to the prevention of alcoholism would include attention to sex education in early childhood.

Let us look at divorce. When the question, "Why do marriages break up?" is asked, the obvious answer is that the couple did not get along. Then, we ask why they did not get along, and after many superficial reasons are given, we learn that in both partners there have been carried over from childhood many personal conflicts that are sexual in origin. Thus, if divorce is to be prevented we must start with the child and insure for him a healthier opportunity to learn about himself.

Shall we think of unmarried mothers? Unwed mothers are a disturbing problem in every community. The immediate cause of such situations is that an unmarried girl loses control of herself and gets pregnant. But the problem is ever so much more complicated. In the first place, the loss of control that takes place is rarely due to strong sexual desire. Accordingly, we must ask a whole series of questions: Why does she lose control? Why is she unmarried? Why did she not take precautions against pregnancy? Why did she not marry the man? Why did she not get an abortion? When you struggle through all the things a woman has to do to become

an unmarried mother, it is perfectly clear that her becoming so is not accidental, nor, of course, consciously desired. The girl's behavior is as if it were behavior forced upon her by her own conflicts and frustrations and these conflicts and frustrations are the fruits of her early teachings about sex.

We may well think of juvenile delinquency. Juvenile delinquency in all its various forms, is easily shown to have very real, very strong causes leading back to early life. Delinquency may be a protest or a defense against society, or it may be a protest or a defense against forbidden and shameful desires, or it may represent the repetition and perpetuation of behavior which in early childhood was quite normal. The sexual implications are obvious and we must realize that little progress in the prevention of delinquency will be made so long as children receive distorted ideas about sex.

We would not want to overlook the problem of mental disease. Mental disease will put one out of twenty of us in a mental hospital. Among the most important causes of mental disease is an inability of a person to get along freely with other persons and to enjoy getting along with others. The most important hindrance to good interpersonal relations consists of prejudices or fears that have a sexual core. If mental disease is to be prevented, great attention must be paid to sex education.

Neuroses, commonly called nervousness, are so frequent that one out of ten persons is partly or completely incapacitated by neurosis in one of its many forms, and many more than that have lesser neurotic symptoms. A neurosis always has its roots in sexual life and we can say that a severe neurosis and a satisfactory sexual life are quite incompatible. If neuroses are to be prevented, it is obvious where we must start.

Many other important conditions are dependent upon the health or unhealth of early sexual attitudes, such conditions as sex perversions, homosexuality, criminal sex offences, all of them major problems in every community.

Now, if it has been possible for you to believe even a little bit of what I have been telling you—if you have been able to go along with me at all, you will understand something of the importance of adequate sex education. The patients I told you about all had sexual difficulties that acted as causes of their troubles; the quick review we made of half a dozen health and welfare disorders similarly showed that prominent in their cause are sexual conflicts and difficulties.

Sexual conflicts, therefore, can be said to stand as the common core of a host of man's ailments, both social and medical. Sex conflicts are not the only cause of these troubles, for there is always a dynamic sequence in the production of any behavior disorder, but the sexual conflict may well be the starting point. Once the sequence of events is started many factors determine the course. Continuing

sex conflicts will always be an important influence but there will be other influences pushing the falling individual toward alcoholism, neurosis, divorce, delinquency, mental disease, illegitimacy and so on. Occasionally someone comes through relatively unscathed, and he is called normal.

If there is any truth at all in what I have said, namely, that there is one cause held in common by a dozen or more serious problems of health and welfare, then it is obvious that the most economical, most successful way to solve those problems will be an all-out attack upon the one point in causation that is common to all. Such an attack upon this common cause means just one thing, it means that children must be helped to learn the truth about sex; to learn how to live comfortably with sexual desires; to learn through knowledge rather than through fear how to be the real masters of their sexual life.

That is sex education. That is what sex education means. Sex education can do these things and must do these things, for nothing else will. But to do these things sex education must be properly undertaken, adequately undertaken. Sex education should start when a child is about two and should be practically complete by the time he is eleven. Sex education should not be a separate subject for teaching; it should instead be woven into all his other learning. We need not at this time go into detail concerning content and method of sex education; suffice it to say that if an adequate program is to be developed it will be a task of tremendous magnitude.

Sex education is actually bigger than mental disease, bigger than venereal disease, bigger than divorce and alcoholism. Because it is so big and so important, sex education should not be the responsibility of any one affected group; it should not be carried on by psychiatrists whose main interest is the prevention of mental disease and neuroses, or by Alcoholics Anonymous whose main interest is alcoholism, or by dermatologists whose main interest is the prevention of venereal disease, or by lawyers or clergymen whose main interest may be prevention of divorce or delinquency.

This job of providing adequate sex education for children is the biggest undertaking ever conceived on behalf of children, excepting perhaps the whole of the present public-school program itself. The job is so big that all interested and affected groups must combine their skills and efforts in developing a functional program, and in presenting that program to parents and to educators.

Even with the combined skill, energy and support of a dozen community groups, a sex education program of any size and any value will meet unbelievable opposition. Direct opposition will be prominent but will not be so difficult to overcome as will be the many indirect and disguised forces that will appear on every side to militate against an effective sex education program.

As an example of the depth and breadth of the public feeling about sex, I can say with certainty that I shall offend and anger

some of you here today by the statements I shall make. Others of you, although not angered or offended, will have feelings that are nevertheless hostile. Each one of you, in fact, will find it necessary to set up at least a few defenses against the very things now being said to protect your own private fears and beliefs about sex. To help yourselves to establish and maintain these defenses some of you will say I exaggerate, others will say that my reasoning is unsound, still others will say that my facts are not facts at all. A few of you will use the biggest but the weakest defense of all—you will reassure yourselves that all sex is immoral and there is no need to discuss it or to listen to it being discussed. All of us, I repeat, put up defenses that prevent us from examining sex objectively. I include myself when I say that all of us put up defenses. I recognized some part of my own conflict while preparing this talk; I feared that I might be too aggressive, too frank, too dogmatic—perhaps I am.

Opposition to an understanding of sexual matters is found in the most unexpected places. To find opposition in the church would not be surprising but opposition there is often less marked than in the medical profession where one might reasonably expect a more ready acceptance.

Some doctors and medical students are particularly resistant to anything that has to do with sex. The other day a medical student in my clinic said he wanted to ask me a question. His question was: "Don't you think the importance of sex is greatly over-emphasized?" When I said that his question didn't sound much like a question, he reflected for a minute and then said I was right, it was not a question, it was a statement . . . he did believe sex was greatly over-emphasized. I did not argue with him, I simply told him to learn from his patients. But he found it hard to learn from his patients. He could not let them talk about their sexual difficulties. He reported triumphantly to me each day that the sex life of the patient he had seen was normal. One of these patients told him she was "innocent" at the time of her marriage. He accepted this as being normal. When she came back the next day I had a brief talk with her and she told me of having been raped by a gang of boys when she was ten and of the dreadful effect this experience had on her. I asked why she had not told the medical student this and she said that he seemed like such a nice boy she didn't want to shock him.

Part of the opposition arises from false ideas of what sex means. Sex is too readily confused with genital activity. Genital activity is important but sex has a much broader meaning than that and in this broad sense no one can escape the influence of sex even for a few hours. In fact, the harder one tries to avoid sex the more significant it becomes. A person who cannot let himself think about sex or talk about sex, is really admitting that he is afraid of the dirty thoughts that might come into his mind. The parent who says it is not safe to talk to a child about sex is in reality saying that sex is terribly important and dangerous, which is true—sex is important and dangerous too, but it is only dangerous when it is not

properly understood. Many parents who say all this talk about the importance of sex is nonsense will at the same time send their daughters to a girl's school to be sure that nothing sexual befalls them; or they lie awake nights wondering what their children do when out with their friends; or they completely deny that *their* children have any sexual desires and thus feel perfectly safe until something happens, when they are filled with amazement and bewilderment.

Actually, it is absurd to think that opposition of any kind can prevent sex education. Opposition can effectively prevent healthful sex education but it will at the same time increase inaccurate, distorted sex education. All children get a lot of education about sex and they always have. Even the most scrupulous avoidance by parents and others of saying anything about sex is sex education. In fact, avoidance is the most emphatic kind of sex education—the child in effect is being educated constantly and definitely to believe that sex is so bad it cannot be mentioned, that sex must be denied, that, in fact, there is no such thing as sex at all. All children even as young as three or four develop ideas and feelings about sex and by the age of ten these ideas are rather fixed. Opponents of sex education must be helped to understand that keeping the truth from children can only result in their acquiring distorted, inaccurate, false ideas of sex which quickly become personally and socially costly.

Several groups of people should be expected to have more than usual understanding of the importance of sex in human life and in these groups little opposition should be met. Medical men, particularly psychiatrists, should have no doubt about the importance of sexual fears, taboos, conflicts and inhibitions; they should have no doubt because they are among the first to see forcefully and directly all the harmful effects in their patients. Some psychiatrists, however, are not as aware of these factors as they should be because even psychiatrists may have blind spots.

Social workers have a fairly complete awareness of the extent of this problem though some social workers fall into the easy error of believing that sexual difficulties are peculiar to their clients and that sexual difficulties do not occur in the lives of their friends.

Clergymen in their pastoral work meet an endless array of sexual difficulties and they, as we all do, feel properly distressed at the magnitude of the problem.

Lawyers meet sexual problems in direct and tragic situations and should have no illusions as to their significance.

Teachers are confronted daily with the fact of sexual interest and sexual concern in children. And teachers well know that stifling sexual interest and ignoring sexual concern contribute greatly to the personal, educational and social problems of children. Some teachers, of course, do not want to see these things, refuse perhaps even to admit that sex exists in children and it is no wonder that to such teachers all children appear to be quite incomprehensible.

Actually, all of us should be perfectly aware of the importance of sex. We all see it affecting people around us every day, affecting our friends, our relatives, ourselves. Yet we go on deluding ourselves that it is not so.

There is a report now available that should dispel ideas that anyone may have that sex is a small matter affecting only a few people. I refer to *Sexual Behaviour in the Human Male*.[1] I recommend this book to all of you. You won't find it pleasant, but it will be illuminating. I shall quote a few figures here that may be illustrative.

The report indicates that "Among the males who go to college, about 67 per cent has coital experience before marriage; among those who go into high school but not beyond, about 84 per cent has such intercourse; and among the boys who never go beyond grade school the accumulative incidence figure is 98 per cent." The report also says that ". . . . it is probably safe to suggest that about half of all the married males have intercourse with women other than their wives, at some time while they are married." Furthermore, "69 per cent of the total white male population ultimately have experience with prostitutes." According to rates worked out by the study, in a city the size of Greater Cleveland (1,300,000), there are 41,470 contacts with prostitutes each week. It is pointed out, moreover, that prostitution constitutes only one tenth of the total non-marital sexual contacts. Other figures given in *Sexual Behaviour in the Human Male* indicate that many sexual practices formerly thought by the public to be rare and occurring only in degenerate persons are actually common and widespread. Anyone reading the report should get quite a new awareness of how we, the people, live.

Some of you, however, will be shocked at these figures. Some of you will immediately discredit them. It is, of course, your privilege to discredit them or to explain them in any way you wish. But discrediting them or rationalizing them will not change figures that appear to be soundly based and repeatedly found. If we are ever to understand human behavior we must first know what some of the facts of human behavior are, and we must not be frightened or shocked by either the facts themselves or by their implications, into closing our eyes to those facts.

Social hygiene leaders in the past did not close their eyes to the facts. Today and with every day that passes, and that brings us more closely related to one another as scientific ingenuity reduces distance and difference between us, social hygiene is even more important than it was in the past, and social hygiene supporters must not now close their eyes to facts.

Today social hygiene is confronted with the need to make momentous decisions, decisions that need clear and courageous thinking.

[1] *Sexual Behaviour in the Human Male*. Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin. W. B. Saunders Co., Philadelphia, 1948.

The main decision that must be made concerns the two jobs social hygiene is now doing. The first job, as we have seen, is the prevention and cure of venereal disease, a truly major health and welfare project having ramifications in all parts of the community. This venereal disease job is a challenge to the best brains in the medical, nursing, social work and legal professions, and the biggest challenge of the job still remains to be tackled: to discover and to apply immunological methods that will lead to the total eradication of syphilis and gonorrhea.

The second job of social hygiene is to change, through education, human sex behavior. This second job was originally undertaken as a means of reducing venereal disease infection but it is now known to have a much wider effect. Changing human sex behavior, we now know, has a great influence on alcoholism, neuroses, divorce, sex offenses, mental diseases, delinquency, illegitimacy, and many other medical and social disorders. Moreover, it is reasonable to assume that healthy sex attitudes and behavior will improve the general level of happiness and success in life.

There is no doubt, therefore, that this second job of social hygiene has become the bigger of the two; has in fact become one of the biggest potential jobs in the entire community. It is upon this point that a decision is now needed. It must be decided whether sex education shall remain an adjunct of venereal disease control; whether the two jobs can find sufficient room to expand together under one sponsor; whether some other organization can better do the job; whether a new agency is needed; whether the job should be done by parents and teachers!!

I, myself, believe, and strongly do believe that sex education must become part of a child's general education, both at home and at school; I believe further that sex education should not be undertaken as a side line by any one group, whether that group be psychiatrists, lawyers, venereal disease experts, social workers or clergymen. This is a job for parents and for professional educators. We who are concerned should help and support parents and educators in making plans for the future, plans for a future that will provide a real education for healthy living. No one is excused from helping and supporting. This is your job and my job—it is a big job, a tough job, but it is a job that must be done and can be done if you and I and all of us get together and work together.

A PSYCHIATRIC APPROACH TO THE TREATMENT OF PROMISCUITY

EXCERPTS FROM

A FURTHER REPORT OF A PSYCHIATRIC STUDY MADE UNDER THE AUSPICES OF THE VENEREAL DISEASE DIVISION, UNITED STATES PUBLIC HEALTH SERVICE, THE CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH, AND THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

JANUARY, 1943, TO JULY, 1947

EDITOR'S NOTE: *In January, 1943, a Psychiatric Service was set up in the San Francisco City Clinic, its purpose being to determine the personality and environmental factors that motivate the promiscuous behavior of the patients referred and to attempt psychiatric treatment to assist them in making satisfactory adjustments, thus removing the likelihood of their behavior leading to the dissemination of venereal diseases. The San Francisco Department of Public Health was interested in determining the causative factors in promiscuity so that a remedial program might be set up on a scientific basis from a long range point of view. The aim of the contemplated program was prevention among the potentially promiscuous as well as among promiscuous patients. In the first year and a half of operation the Service studied 365 women patients of the Clinic—all either promiscuous or potentially so, according to criteria established by the Service staff, and in 1945 a first report on the project was released through the* JOURNAL OF VENEREAL DISEASE INFORMATION, *under the title* AN EXPERIMENT IN THE PSYCHIATRIC TREATMENT OF PROMISCUOUS GIRLS.*

The interest aroused and the results achieved by "the San Francisco experiment," as it came to be known, has led to a continuation and an expansion of the Psychiatric Service as a peacetime civilian project, and its sponsors have now released another report reviewing some of the findings of the early study, and covering the period up to July, 1947. The JOURNAL OF SOCIAL HYGIENE *presents here selected excerpts from this second report, which will be published in full by the American Social Hygiene Association early in 1949, under the title shown at the head of this page. (Publication No. A-741; price 75 cents.)*

The report was prepared by members of the Psychiatric Service staff, DR. BENNO SAFIER, *Director;* HAZLE G. CORRIGAN, *Chief Psychiatric Social Worker;* ELEANOR J. FEIN, *Assistant Psychiatric Social Worker, and* DR. KATHERINE P. BRADWAY, *Psychologist. The project has had throughout the approval and guidance of* DR. J. C. GEIGER, *Director of Public Health for the City and County of San Francisco, and of* DR. RICHARD A. KOCH, *Chief of the Division of Venereal Diseases.*

* Lion, Ernest G., Jambor, Helen M., Corrigan, Hazle G., and Bradway, Katherine P. *An Experiment in the Psychiatric Treatment of Promiscuous Girls.* City & County of San Francisco Department of Public Health, 1945.

The Chapter headings give an idea of the trend and scope of this valuable contribution, which it is believed will be welcomed by all concerned with social hygiene activities:

Chapter I. Objectives and Functions of the Psychiatric Service . . . **Chapter II.** Biographical and Descriptive Data Regarding Patients—sex, race, age, and religion; marital status and parenthood; family background and relationships; education, vocational training, employment, and income; residence and living arrangements; social relationships and recreation; court and institutional experience; military service; venereal diseases; intelligence; personality characteristics, neuropsychiatric diagnoses . . . **Chapter III.** Dynamic Factors in Promiscuity—women and men patients; psychosexual development; motivation for habitual promiscuity . . . **Chapter IV.** Treatment of Promiscuous Patients—general therapeutic considerations; prognosis and treatability; service classifications; use of service by women and by men; follow-up . . . **Chapter V.** Community Considerations—personal adjustment; public health; social welfare.

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This report is a continuation of the study of the application of psychiatric knowledge and techniques to venereal disease control, first reported upon in 1945. Such an approach to venereal disease problems was a new departure in 1942 when public health officials sought the aid of psychiatry in meeting the war-time problems of venereal disease and the resultant loss of essential manpower. In this project, problems of sexual promiscuity were studied and psychiatric and case work treatment was offered to promiscuous and potentially promiscuous young men and women.

The project was a clinical study carried on cooperatively by psychiatrists, psychiatric social workers, psychologists, and public health workers. During the four and one-half year period from January, 1943 through June, 1947, a total of 1,557 patients were seen in the Psychiatric Service; 1,189 were women and 368 were men. Of these, 365 women and 255 men were included in the research study and are reported upon here.

The earlier report recommended that the study, originally limited to women, should include men, and that services should be extended to include other health department clinics. Beginning in July, 1945 the study of promiscuous and potentially promiscuous men was undertaken. Also, for a two-year period services were extended to the health department diagnostic center for women. Work on the recommended study of screening of patients for service and treatability has not been completed.

* * * * *

The chief objectives of the project were to determine the factors motivating promiscuous behavior and to determine to what extent psychiatric and case work treatment might be effective in assisting the promiscuous and potentially promiscuous patients to make satisfactory adjustments and specifically in assisting them to reduce their promiscuity.

The study and treatment of these patients was by a clinic team consisting of a psychiatrist, psychiatric social workers, and a psy-

chologist. Social histories were secured from all patients. Patients were routinely referred for psychiatric examinations and on a selective basis for intelligence testing, Rorschach studies, or other psychological evaluation. Attendance at the service was voluntary and treatment was individualized.

For the purposes of this study, promiscuity was defined broadly. A total of 208 women and 181 men were classified as promiscuous and 87 women and 62 men as potentially promiscuous. Seventy women and 12 men could not be classified.

Referral of the patients was chiefly from the San Francisco City Clinic, in connection with which the Psychiatric Service was operated. Both infected and noninfected patients were included. Age was the principal factor in the selection of patients, the group falling mainly under the age of 25. Race was controlled for the men so as to give the same distribution as for the women.

A comprehensive study of the social and personal factors, both current and past, was made for each patient. Certain similarities as well as individual differences appeared from case to case. No single factor or group of factors could be isolated which would in themselves either determine or exclude promiscuity. *Unsatisfactory familial relationships, often including broken homes, and unsatisfactory interpersonal relationships were among the factors which appeared to have a direct relationship to promiscuous behavior.* The sex instruction which these patients had received was usually described as inadequate and unscientific. Conflicts of various types with reference to sex were seen in a majority of patients. Uneven development in the areas of physical, intellectual, emotional, and social maturity for the individual patient was frequently found. Emotional and social immaturity, characterological instability, and, for the men, passivity were typical of the promiscuous patients. The occurrence of neuropsychiatric conditions and neurotic tendencies was frequent. *Promiscuity appeared in most cases to be symptomatic behavior arising out of neurotic conflict. Current environmental factors such as unsatisfactory living conditions, the absence of community ties, and the making of casual friendships were often found to have contributed to the promiscuous behavior, but could not be considered as the primary cause in any case of habitual promiscuity.*

No evidence was found that the promiscuous patients had greater than average sensuality or sensuousness. Further, in general, the degree of satisfaction derived from sexual relations was impaired.

One hundred thirty-nine of the promiscuous women (67 per cent) and 138 of the promiscuous men (76 per cent) showed a continuing pattern of casual sexual relations and were classified as habitually promiscuous. Most of the remaining patients were episodically promiscuous.

The motivation of promiscuity in the habitually promiscuous patients was studied. With a few exceptions, such promiscuity was found to be the result of difficulties within the personality—conflicts, inadequacies, or other disturbances.

The largest motivation groups for both men and women were those described as the Actively Conflicted group, whose promiscuity was an expression of intrapsychic conflicts. Of next importance for both men and women were the much smaller Maladapted groups whose promiscuity was a part of the maladapted behavior characteristic of the unstable patient who lacks social responsibility and self-restraint.

Two-thirds of the women and one-half of the men made use of the services offered. A small group of these patients used long-time, intensive treatment, assuming responsibility for attempting to improve their adjustment. Considerably more of the women than of the men used long-time treatment. The patients using limited service were seen on the average for two to four interviews. As indicated, the women used more service than the men. Level of intelligence was also related to use of service, the significant increase in use of service coming at about I.Q. 80 for the women and I.Q. 90 for the men. Race proved a factor in the use of service for the men only, the Negro men using significantly less service than the white men. Within the age groups of the patients studied, age was not a factor in the use of service. The Actively Conflicted motivation groups used more service than other groups of habitually promiscuous patients.

The observation of patients during the course of treatment suggested that they had benefited from the services given and, in particular, had reduced their promiscuity.

Follow-up at six months and in many cases at 12 months or more for those patients who utilized long-time intensive treatment revealed dramatic improvement in most cases. Of the 68 per cent for whom follow-up data was completed 88 per cent had reduced their promiscuity (or if potentially promiscuous, had not become promiscuous), and one-half of these had had no sexual contacts except in marriage within the follow-up period. For those who used short-time services the data were less conclusive. The results were significantly positive for the few who could be followed. Of 21 per cent followed, 78 per cent showed improvement.

The difficulties encountered in many instances when referrals to other agencies were attempted led to the conclusion that referral should be attempted only for those few patients who saw clearly their need for help from another agency. It was evident that services should be directly connected with the venereal disease clinic if these patients were to be reached successfully. In addition to the fact that they did not avail themselves of the services of other community agencies, it should be noted that a specific need presented itself for these patients—that of help in meeting the emotional experiences associated with venereal disease.

The experience of the Psychiatric Service has demonstrated that psychiatric facilities in connection with a venereal disease clinic can contribute to venereal disease control by treatment which results in reduction, modification, or elimination of promiscuity among carefully selected patients who voluntarily utilize the services. Although

emphasis should be placed upon services to women because of their more frequent and more intensive use of service, the provision of services for selected men should not be overlooked. Through all such treatment the twin objectives of venereal disease control and mental hygiene are promoted.

Recommendations

The following recommendations are the outgrowth of analysis of the findings of this study:

1. The psychiatric facilities within the San Francisco City Clinic, primarily for the purpose of service to promiscuous and potentially promiscuous young men and women, should be continued; more adequate coverage for other venereal disease patients within the Health Department should be provided; short-time services including referral to other agencies should be available upon referral for all health department and clinic patients whether promiscuous or not.

2. There should be further research on treatability and on the screening of patients for referral to the Psychiatric Service.

3. Consideration should be given to the provision of an organized plan for instruction of medical and nursing personnel which should include:

a. Information regarding the dynamics of human behavior.

b. Application of this information in the selection of patients for referral to the Psychiatric Service.

c. Application of this information in the interviewing situation.

4. Services similar to those of the Psychiatric Service should be developed in connection with venereal disease programs in other cities.

5. The possibility should be considered of utilizing the facilities of the Psychiatric Service to offer specialized training for professional personnel for similar services elsewhere.

6. Preventive services on a broad community basis should be promoted. These would include

(1) General education measures:

a. Preparation for marriage and parenthood.

b. Dissemination of information to parents and teachers regarding the child's emotional development, particularly with reference to preparation for sex instruction and guidance appropriate to the child's needs.

(2) Special services:

a. Adequate family service facilities and other safeguards for wholesome family life.

b. Adequate mental hygiene services in schools, clinics, and general hospitals aimed at discovery and early treatment of emotional problems of children.

This report of our findings was prepared especially for the large group of public health workers—doctors, nurses, and social workers—who day by day are dealing with the problems of venereal disease and for the public health officials who may find in it an answer to some of the problems of venereal disease control. Our hope is that it will be of value also to those in our respective professional fields and to teachers, civic leaders, and parents.

We believe that our project has demonstrated the need for psychiatric and case work services within a venereal disease clinic and the value of such services in reducing the spread of venereal disease as well as promoting the mental health of the patients treated.

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THE VENEREAL DISEASE PATIENT AS A DELINQUENT

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One factor that complicates the control of venereal disease in our society is the fact that the patient is so much a figure of drama. In the eyes of his friends, of his community, of his doctor, even in his own eyes, he is never an ordinary sick man, but a delinquent. No matter how mild or easily cured the disease may be, he is left with a blot on his reputation and with a wound to his self-esteem that never really heals. The spectre of death that haunts the tuberculous and the frustration of the physically disabled are personal. But venereal disease leaves a man with a sense of guilt and of contamination that set him apart. He may hide this under the bravado of having seen life or may intellectualize about the completeness of the cure but he does not forget.

A program to rid the community of venereal disease has to deal not only with those to whom the disease is only a threat but with the emotional reactions of those who have been infected. The spreading of knowledge of the means of avoidance will be effective only so far as the general public is willing to take personal responsibility at all. The handling of the patient however needs to be aimed at not only keeping him in treatment until he is cured but at helping him use his experience in a way that is constructive for himself and the community.

Primitive man looked upon disease as something that came upon him unaware from the outside through the wrath of the gods or the magic of his enemies. It has taken him ages to comprehend his own responsibility for getting sick. Now, the further exploration goes into the human mind, the more it is being realized that people invite, if not create, many of their illnesses. And it is not only through careless exposure that they fall sick, but often through an unconscious need to do so, as a result of unrecognized conflicts. Treatment aims to make conscious the conflicts and solve them in constructive action. But new conflicts arise on an unconscious level and illness recurs in even the psychologically alert.

It is a moot question how much anyone is responsible for his conduct, especially when unconsciously motivated. The determinists claim that all thought and action depend on what has gone before. But most of us believe in free will. We try to teach control of the self and punish those who fail. As individuals we have a conscience and a sense of guilt that indicate our conviction that we can direct our lives as we will. The recognition of unconscious motives does not lessen the effect of a crime. We may try to use punishment as treatment rather than as revenge but even this enforced treatment is aimed at helping the criminal to bring his motivations in line with the common good.

Although society is a long way from seeing illness as an offense, yet many if not most people react with guilt as if they felt it to be so. We reject ourselves for having unacceptable desires even if we do not act on them. We feel guilty and often punish ourselves as if we had given in to the desire, and illness is often the result. The world is not very lenient toward emotional illness. When it is learned that a person's sickness is due "just to nerves," there is an almost immediate reaction on the part of his associates to blame him and to deny him the consideration that he would get if a physical cause were indicated. If he eats badly, overtires himself, is indiscreet in many other ways that bring on illness, he is looked upon as unwise but is allowed to be ill. But sickness due to "nerves" is not to be tolerated and the patient himself feels inwardly responsible and guilty. If, as the result of increased understanding, the psychosomatic nature of a great deal of sickness is widely recognized, is the sick man to be treated as an offender and punished rather than pampered, as now?

The one type of illness that we do openly blame upon a patient is venereal disease. Perhaps it is because the connection between behavior and its result is so direct that we are more ready to hold him responsible and to treat him punitively. Actually he is probably no more responsible than the victims of other diseases. He becomes infected in the search for satisfaction of as natural an appetite as the desire for food. We good-humoredly condone gluttony and mild alcoholism and even sympathize with the after-pain of the overindulgent. But the sexual activity that leads to venereal infection is not forgiven and society adds to the inner guilt of the patient a cold rejection. No matter how much we may understand the individual experience of the patient, which has ultimately led to the infection, no matter how much we recognize that our customs stimulate sexuality while denying it a legitimate outlet, we blame the patient and he feels a guilt that must be reckoned with in his treatment.

All people feel guilt of some kind, which is more than a fear of punishment. When we have this conviction of having done wrong, no matter how we hide it, we are not really satisfied until we have in some way cleared ourselves. In fact, if punishment does not come, we are often unconsciously driven to seek it out. The traditional idea that the criminal returns to the scene of the crime is not untrue. In some cases guilt for an unpunished act may push a man on to further misdeeds. Not having been punished as he thinks he deserves, and lacking the courage for open confession, he invites punishment by another crime as a way of easing his discomfort. And so arises a sort of compulsion to get into difficulty for which he eventually receives retribution.

The guilt of the venereal disease patient arises, of course, not only from the acquiring of the disease but from its being an evidence of sexual misconduct. Regardless of how ignorant or stupid a man may be, how brutal or insensitive, he has grown up in a social setting in which standards of sexual behavior exist. These standards,

however degraded or neglected, have not vanished and we still impress upon children the idea that sex activity outside of marriage is wrong. The lowest of prostitutes, like the most emancipated of intellectuals, still has to justify to himself his unmoral behavior. Defiance of the old code may be general, may at certain times be socially fashionable, but we still cling to the ideal of monogamy. And when venereal disease comes as a result of disregard of the code, it inevitably arouses a sense of guilt and a feeling that the punishment is deserved. In the long offender against society this guilt may be buried in the morass of unsettled guilt for other offenses so that it is hard to recognize, but it enters into the whole feeling of wrongdoing.

Guilt is a very useful feeling. It is a natural product of the awareness of our relation to others. More deeply, it is the result of the betrayal of the social instinct in man that wars eternally with his desire for individual satisfaction. Even without the moral training that parents attempt to give to their children, each one of us would develop something like this social instinct from the reaction we meet with when we infringe upon the rights of others. Our legal codes and the ethics of our religions try to define the line between individual privilege and the common good. We cannot grow up in society at all without some code of behavior and a resultant sense of guilt when we transgress.

But guilt is of various kinds, arising at various levels of feeling. One may be plagued with only the most superficial sort, from which it is easy to escape, or the guilt feeling may penetrate into the deepest layers of personality, as in the profound neurotic. At any level, it is an incentive toward action, if only to escape from the pain it causes. We may seek to undo directly the action that has created this discomfort. Or, the uncorrectable fault, even when repressed into unconsciousness, may give rise to more general good conduct as an atonement. Only when guilt is misdirected or unatoned for does it become a source of pathological disturbance to mind and body.

Most obvious and most widespread is what may be called social guilt. This consists essentially of the concern about "what will people say!" Many a culprit can be comfortable if he can hide his guilt from the world. His awareness of others is largely only a fear of their criticism, without a real identification with the group or a sense of responsibility toward them. He may be haunted by a fear of discovery of his misdeed and may resort to deceit to hide it, without feeling guilt for this deceit. The passage of time without punishment lulls his fear and he may seek comfort by comparing himself with others, no better than he. At the best he learns to conform and forget the past. At the worst, he comes to feel that his success in concealment warrants further evasion of the code and that what is hidden does not exist. His social conscience is embryonic and he exploits rather than contributes to society. Still he has guilt of a sort that may be reawakened and become troublesome if not used constructively.

Somewhat deeper is the kind of guilt which consists largely in the fear of losing the love of family and friends. Behavior that is concealed from the world is more easily detected by this group and if detected is more readily condemned because it reflects upon them all. As a result this group guilt is more personal and produces more tension and anxiety than social guilt. Even flight from the community does not usually break all family ties and any new set of intimates has again a standard to be lived up to. There are a few really solitary people who have no close associates, but for most of us the rules of our group strongly affect our behavior. And our social instinct creates a deep fear of rejection by the group and of isolation if we offend too much against their code. The dread of discovery of such an offense is a large element in the guilt we feel toward the group but, in so far as we are really identified with them, we condemn our behavior ourselves and feel the discomfort of self-criticism.

Even deeper and more agonizing is ego guilt—the feeling that one has been a fool, has failed to measure up to the concept or image that each holds of himself. It is the more painful because it cannot be hidden away except by eventual repression into the unconscious, where it still rankles and may give rise to uncomfortable dreams or even to symbolic neurotic symptoms. It is harder to forgive ourselves than others because of our inner self-love. It is painful to be wounded by others but when we fail ourselves it is worse. It makes us doubt our adequacy to meet life and the memory of failure haunts us in the night. We try to throw the blame on others or we parade our achievements to balance the fault but only a later success in living up to our ideal can wipe away the stain.

Deepest of all is religious guilt, the sense of having failed God. The world has not become as pagan as many might think, as one looks at the social scene. In times of stress the need to turn to a belief in a supernatural power still comes to the fore and the teachings of childhood are recalled. The early church recognized the great burden imposed by guilt and provided the confessional as a relief. The mere verbalization of a sense of sin opened a way to forgiveness. The penance imposed served as a positive way of atonement and relieved the tension of internal anxiety. The modern psychiatrist knows the value of this ventilation for even the more superficial kinds of guilt but the priest has long known the healing effect upon the self-rejecting soul.

Guilt of whatever kind is a painful thing and is more widespread than is always recognized. All four kinds or any one kind may arise in response to behavior. In fact there may be conflict created between these different types. The criminal may have a deep sense of guilt for what he has done and may be driven to confess it. To do so however is a sin against the gang with whom he associates. Whichever guilt he feels more strongly will drive him to action which creates new guilt toward either himself or his group. At some level, the acquiring of venereal disease always gives rise to

guilt. It may be the ego guilt of feeling he was a fool for being careless, it may be religious guilt for sinning against the code of his church, it may be a sense of having brought contamination into the family circle or it may be a social sense of having been involved in spreading a disease in the community. To some extent, however small, guilt is present and if the patient, not merely the disease, is to be treated, this guilt too must be dealt with. The more sensitive man may feel that in his infection he has met with the punishment his irregular sex conduct merited and he may unconsciously welcome the pain and exposure the disease brings. But even for him this punishment is usually not enough and, if one thinks of the tendency for the unpunished guilty man to seek that punishment by continued anti-social conduct, it is necessary to consider to what extent punishment of some kind must enter into the total planning of control of the disease. How far should the patient be held responsible for his illness and how should his guilt be handled?

There is current today a potentially dangerous tendency to free people from personal responsibility for their conduct of any sort. Many kinds of protection can be provided only by large scale activity, beyond the power of the individual to carry out. Also, the growing recognition of the part that unconscious motivation enters into human behavior tends to give the feeling that no one should be held entirely responsible for even his anti-social behavior. Especially, it seems, in the field of health, is the individual being called upon to take less and less personal responsibility.

Preventive medicine has gone far in protecting man against the disease-producing agents that threaten him from the outside. It has discovered the causative factor in most of these diseases, has built barriers of various kinds against them and has widely informed the public about these measures. Therapeutic medicine has at the same time found new means of treatment and surgery has learned to cut into and repair the most delicate organs. Modern health schemes go farther than early health departments conceived of when they saw the need of community action against contagious disease. Now, to some, it seems essential that through compulsory insurance care be provided in all fields, therapeutic and surgical as well as preventive. People are to contribute financially rather than by individual safeguarding of their health and to leave to a subsidized profession the entire responsibility for keeping them well. This is, to be sure, merely part of a broader trend to protect men against their stupidity and lack of foresight. Compulsory contribution to schemes of social security and unemployment insurance are to make up for his lack of thrift. Radio advertising tells him carefully what and where to buy and news commentators save him from having to interpret current events himself. Workmen's compensation provides for him if in spite of safety devices he gets hurt. The result is a vast improvement in the physical welfare of most people, whose health, wealth and freedom from anxiety are greater than ever before in history. Since without these various types of protection

he had not been able to achieve such well-being, the element of compulsion and its infringement on his freedom are forgiven.

But, in certain diseases as in certain types of accident, individual alertness is the only final source of security. Safety devices are effective only if people obey their rules. One may speculate as to whether the dependence on outside protection, now so common, has made the average city dweller lose his natural tendency to think for and protect himself so that the obeying of rules for his safety must require further compulsion. The city may provide pure water and inspected food but the people must use only these to keep well. So we may regulate or eliminate commercialized vice and provide prophylactic resources but individual attention is still necessary to prevent disease. We seem to be at a stage where enough protection has been provided to make people less cautious, without having achieved perfect protection in any field of health which will operate for even the most careless. We have, on the other hand, developed prompt remedies for the victims of their own lack of caution so that improvidence no longer brings disaster. As a result, it is difficult to arouse people again to a sense of the need for their participation in any campaign to eliminate a potential menace to their welfare. They expect their paid specialists to do all the work for them, feeling they have done their best by giving out money.

In general, one may recognize that the venereal disease patient, as an average member of the community, has not been very active in protecting himself and is inclined, like others, to expect the medical profession to protect and cure him, while he looks on. He has been shocked and is fearful at the discovery of the disease and turns docilely to a doctor for help. He wants a cure at as little expense as possible to himself, in money or effort. He feels guilty and afraid but does not analyze the nature of his feelings, wanting only to be made comfortable again. The way in which he is handled at this point may set the tone of his response to the treatment, as well as of his later social attitude. The current rapid methods of treatment may be of great benefit to him physically but leave him unaware of his need for a change in attitudes. More than ever now, it is important for the doctor to make prompt use of his relationship to the patient to ensure not only the cure of the disease but also the protection against future reinfection and the patient's participation in safeguarding the community.

The first step in dealing with his attitudes is to set an atmosphere of acceptance that will relieve his anxiety and maintain his self-respect. He must be helped to think of himself as first of all a sick man, not a pariah. He may need a certain amount of impersonal instruction as to the nature of the disease, the way in which infection occurs and can be transmitted, and the essence of the treatment. Sometimes such general information is best given in a printed pamphlet. It must not be overlooked, however, that most people have a very garbled idea about disease and particularly about one so much involved in the folklore of sex. The fact that he has

a college degree does not guarantee his freedom from distorted notions. One should not hesitate to speak in the simplest language about the simplest facts, leaving opportunity for question, however naive. Just this impersonal discussion, without elements of blame or inquiry into the source, may allay anxiety, give assurance as to the doctor's adequacy and interest, and allow for thinking about the practical adjustments in his life that must be made in his treatment plan.

It may require several visits before he is enough at ease to permit talking about his emotions. It is advisable to assume that his feelings are deep even if he seems unconcerned. One may speak of the fact that all in his predicament are not only fearful as to the experience but embarrassed about it. This embarrassment is a sort of acknowledgment that they feel responsible and it is well for them to consider just where the responsibility lies. It is natural for them to have sexual needs but how did it happen that they sought to satisfy them with a person who could infect them? Can they tell about the incident, without mentioning names? What had been their previous experience and how much trouble have they had in working out a satisfactory adjustment? Have they had moral scruples about their conduct? If the infection is due to extramarital or premarital activity, what is their opinion about such activity in general? Where do they see the community as failing them? What have they themselves done to participate in community handling of the matter of sex activity outside of marriage?

One might lead on from there to a discussion of their own sense of guilt or at least responsibility. Keeping in mind the four types of guilt, social, group, ego and religious, one might explore into these on the basis that facing guilt is the beginning of relieving it. From there it is possible to go on to talk of atonement, the need for punishment of some sort, the role of treatment as punishment and the possibility of taking part in the community attack upon the disease as an atonement. This gives a reasonable basis for asking the name of the possible source of infection, not in terms of punishing this source, but for the sake of the general welfare.

Meanwhile physical treatment has been started and the patient's interest in the discussion serves as an additional reason for continuing to come. The speed of developing the discussion needs to be adapted to the patient's ability to talk and it must be carried on at a level consistent with his intelligence and sophistication. There need be no attempt to dig into the unconscious material although the doctor may recognize that a neurotic conflict exists and may eventually encourage psychiatric handling. The discussion at a surface and practical level may be all the patient needs if the relationship is good.

The justification for such dealing with every venereal disease patient lies in the recognition that he does feel guilt; that guilt can give rise to repetition of misconduct if it is not relieved; that

the experience can be used as a constructive contribution to the general welfare of the community and its struggle with the problem of venereal disease; and above all that competent treatment of any sick man must include him as a person, not only his disease.

Regardless of how tolerant we may feel toward the victim of venereal disease, seeing him as the product of a confused social situation, yet his being infected proves that he has in some way gone against the rules of society and has disregarded the means of protection provided for him. To that extent he is actually a delinquent and as such needs to be treated for the attitudes that led to the delinquent behavior. We know that in other forms of delinquency mere disapproval and even punishment do not prevent crime. Understanding by the delinquent himself of the causes that led to his misconduct may give clues to his real needs. But the guilt aroused by feeling or acts can be kept from destructive effect upon the individual and the community only by frank acknowledgment of fault and atonement through constructive action. The venereal disease patient has acted as a delinquent and should be handled as such. And the effective handling of his guilt can provide one of the most productive agents in the task of eliminating the disease from society.

Current Events and Dates Ahead

February 2	**NATIONAL SOCIAL HYGIENE DAY.** *PROTECT THE FAMILY . . . STAMP OUT VD.*
February 2 Washington, D. C.	THIRTY-SIXTH ANNUAL MEETING. **AMERICAN SOCIAL HYGIENE ASSOCIATION** AND REGIONAL CONFERENCE WITH THE **SOCIAL HYGIENE SOCIETY OF THE DISTRICT OF COLUMBIA.**
January 26–29 Boston	**American Association of Schools of Social Work** annual meeting.
January 31–February 1 New York	**National Social Welfare Assembly** annual meeting. Headquarters, Hotel New Yorker.
February 20–27	**Brotherhood Week,** sponsored by National Conference of Christians and Jews.
March 16–18 New York	**National Society for Prevention of Blindness** annual conference. Theme: *The Battle Against Blindness—the Next Forty Years.*
April 3–10	**National Negro Health Week**—35th observance. Health objective is: *Cooperate with your health agencies and your neighbors for better health and sanitation in your community.*
April 13–15 Tallahassee, Florida	**National Association of Deans of Women and Advisers to Girls in Negro Schools** annual meeting.
Throughout 1949	**Diamond Jubilee of Nursing,** celebrating the 75th anniversary of professional nursing in the United States. Sponsored by American Nurses' Association.

NATIONAL EVENTS

ELEANOR SHENEHON

Director, Washington Liaison Office, American Social Hygiene Association

National Health Council's Committee on Local Health Units Sets Up Permanent Organization.—The National Advisory Committee on Local Health Units, which has functioned on an interim basis under the sponsorship of the National Health Council for almost a year, effected final organization on December 2 when the Committee met in New York and elected officers for 1949. This is another important step towards the goal set at the American Public Health Association-sponsored Princeton Conference September 8–10, 1947—adequate public health services for every U. S. citizen.*

James Stone, National Tuberculosis Association program director, was made chairman, succeeding Philip R. Mather, Council and also ASHA president, who has served as chairman pro tem. Dr. G. F. Moench, Health Chairman, Congress of Parents and Teachers, is vice chairman and Martha Luginbuhl, Research Assistant, APHA Subcommittee on Local Health Units, is secretary. The Committee now has representation from 51 national bodies, including twenty-eight citizen, and twenty-three voluntary health and allied agencies. ASHA is represented by Mrs. Dwight S. Perrin, board member.

An executive committee as follows was chosen:

Haven Emerson, M.D., American Public Health Association, chairman; Mrs. Stephen Francisco, General Federation of Women's Clubs; Harold Friermood, YMCA; Mrs. Dorothy Hamilton, National Urban League; Harold Nutter, Lion's International, and Joseph V. Tobin, American Federation of Labor.

Dr. Emerson, reviewing progress, stressed support given by the Committee member agencies, and the leadership of voluntary or civic agencies in developing local public opinion. He spoke especially of the sponsorship before the 80th Congress of the Local Health Services Bill of 1948 by the National Congress of Parents and Teachers. It is planned to reintroduce this bill in the 81st Congress. He mentioned also the growth of state aid to local health services, of consolidated health districts in many states, and the resolutions of the Local Health Units Section of the National Health Assembly. These and other developments, Dr. Emerson said, show "a definite spirit of excitement quite in contrast to the inert attitude of seven or eight years ago." He urged every national agency to alert its state and local branches to the significance of legislation in 1949 when 44 state legislatures meet.

Among the actions taken by the meeting was one creating a subcommittee on educational materials to evaluate existing material on "what the citizen may expect from a community health department" and "how to get one" and to prepare further educational aids if they are found necessary. Mrs. Perrin will serve as chairman, and close cooperation from the U. S. Public Health Service is expected on the project.

* For an earlier account of this program of local health units, see JOURNAL OF SOCIAL HYGIENE, June, 1948, page 265.

American Public Health Association Holds 76th Annual Meeting.—Boston was the meeting place for the APHA's 76th annual meeting, held November 8–12, with more than 4,000 of its 11,000 members attending. Meeting at the same time were many related organizations. The conference, set up as usual in general sessions, special sessions and sectional meetings, covered a variety of subjects. Papers on venereal diseases were given in both the Epidemiology and Laboratory Sections.*

Some high points of the four-day meeting were the presidential address of Dr. Martha M. Eliot, associate chief, U. S. Children's Bureau, on *The Cultivation of Our Human Resources for Health in Tomorrow's World;* the presentation of the Sedgwick Memorial Medal Award to Dr. Abel Wolman for distinguished service in public health, and Dr. Louis I. Dublin's talk on *A Centennial of Public Health* which led the New York *Times* to say, "People who are tempted to lament the good old days should consider some facts and figures here presented."

Presentation of the Lasker Awards for 1948, each consisting of $1,000 and a gold statue, were presented to Dr. Eliot and to Dr. Rolla E. Dyer of the National Institute of Health, Bethesda, Maryland, for administrative achievement. The Lasker Group Award went to the U. S. Veterans Administration Department of Medicine and Surgery, with particular honor to Dr. Paul R. Hawley, former VA medical director, and Dr. Paul B. Magnuson, present director. Scientific awards were received by Dr. Selman A. Waksman of Rutgers University, Dr. Rene J. Dubos of the Rockefeller Institute and Dr. Vincent du Vigneaud of Cornell University Medical College. Dr. Donald B. Armstrong received the fifth Elisabeth S. Prentiss National Award in Health Education, Dr. Lester Taylor, president, Cleveland Health Museum, making the presentation at a meeting of the Health Education Section.

APHA officers for 1949 are:

President, Charles F. Wilinsky, M.D.; president-elect, Lowell J. Reed, M.D.; vice-presidents, Guillermo Arbona, M.D., Albert E. Berry, M.D., Florence Sabin, M.D.; treasurer, Louis I. Dublin, Ph.D.; chairman, Executive Board, Hugh R. Leavell, M.D. Two Executive Board members, Leona Baumgartner, M.D., and Thomas F. Sellers, M.D., were elected.

Family Service Association of America Meets in Detroit.—With the theme, *New Forces in Family Living—New Directions in Family Service*, 600 representatives of community family service agencies met in Detroit, November 18–20, for the 1948 biennial meeting of the Family Service Association of America in an endeavor to spot recent and significant developments in American family living and to plan how changing needs may be met.

In addition to general sessions, several sectional meetings on casework, public relations and administration were held. Aware that greater preventive effort must be expended to head off family troubles

* See JOURNAL OF SOCIAL HYGIENE, October, 1948, p. 335, for list of papers presented in this field.

before they reach the breakdown stage, the conference held both general and group sessions on family life education. One paper of especial interest to social hygiene workers who are attempting programs in this field was presented by David Rauch, Educational Director, San Diego Family Service Association, on *How Does an Agency Organize a Family Life Education Program and What Community Needs Is It Designed to Meet?* The San Diego Family Service Association, in response to overwhelming community interest in family life education, organized an educational committee of community leaders, including representatives from the schools, PTA's, women's clubs, State College, planned parenthood, public housing authority, social hygiene, medical association, council of churches, and the adult education department. Students and representative unorganized parents also served on the committee. It was found that the work could be done more effectively through already established organizations, with the FSA furnishing leadership. Most of the discussion groups were sponsored by PTA's, women's clubs, church organizations and Y's. During this two-year program 6,287 people have joined discussion groups, the most popular being parents' discussions of child development, teen-agers who wanted to know about dating and boy-girl relations and young married people talking over marriage relations, budgeting, recreation and making friends. Dividends, according to a San Diego newspaper, have been fewer family breakdowns, fewer separations and divorces and less child delinquency.

Among eminent speakers at the general sessions of the meeting were Dr. Charles S. Johnson, president of Fisk University and ASHA vice-president; Dr. Eveline Burns, professor of social work, New York School of Social Work, an expert on the effect of economic trends on family life and Dr. Helen Ross, administrative director and noted analyst, Chicago Institute for Psychoanalysis.

FSAA headquarters are at 122 East 22 Street, New York City.

Federal Council of Churches Meets in Cincinnati.—Nearly five hundred delegates and church leaders met in Cincinnati, Ohio, December 1–3, for the biennial meeting of the Federal Council of Churches of Christ of America, which comprises twenty-two Protestant denominations and three Eastern Orthodox bodies, with a total membership of 28,000,000 church goers. An outstanding Council action was adoption of a resolution condemning racial segregation as "unnecessary and undesirable," described as the strongest document on human rights ever acted upon by the organization in its 40-year history.

Charles P. Taft, Council president for two years past and a Council representative at the World Council meeting in Amsterdam, Holland, August, 1948, in his presidential address discussed the religious problems of the layman.

Among other speakers heard were Dr. Samuel McCrea Cavert, Council general secretary, who addressed the opening session; Francis S. Harmon, vice-president, Motion Picture Association of America, who discussed lay participation and leadership, and Professor Wil-

ham G. Mather, Pennsylvania State College, who spoke on church policies in the field of human rights. Leonard W. Mayo, dean, Pennsylvania State College School of Social Work, discussed church responsibility for dealing with juvenile delinquency, and the Rev. A. R. Pepper, executive vice-president, Church World Service, told the organization of its responsibility for displaced persons.

Bishop John S. Stamm, Harrisburg, Pennsylvania, senior bishop of Evangelical United Brethren Church, and Mrs. Mildred McAfee Horton, past president of Wellesley College and wartime WAVES director, were unanimously elected president and vice-president respectively. Re-elections included Harper Sibley, Rochester, New York, treasurer, and W. Glenn Roberts, Hartford, Connecticut, recording secretary.

Church Holds National Conference on Family Life.—Immediately preceding the biennial meeting of the Federal Council of Churches the 3rd national conference on family life, with a theme of *Church and Home in a Disordered World*, was held in Cincinnati, November 29–30. The Intercouncil Committee on Christian Family Life, Dr. L. Foster Wood, chairman, representing the family life interests and programs of the Federal Council, the International Council of Religious Education and the United Council of Church Women sponsored the conference. The meeting, functioning in general sessions and sections, was concerned primarily with bringing together a working group of ministers, educators, executives, psychologists, writers, social workers and home makers who are doing significant work in building up family life for exchange of insights and techniques and for consideration of further development of leadership for the family life movement.

Highlighting the luncheon meeting of the first day was an address by Dr. Roy A. Burkhart, pastor of the First Community Church, Columbus, Ohio, in which he emphasized the need for attention to the very early development of the child, stating that an individual's basic personality is often determined in infancy and that most marital guidance programs are therefore too late. He also stated that "feeling tones" developed during childhood may be far more basic for marital success than knowledge acquired later. Dr. Burkhart called on the church to deal specifically with the issues of family life and developments in education for family living. Other speakers at this session were Dr. Warren D. Bowman, Mrs. James D. Wyker and Rev. George Warner, Jr.

Section meetings included discussions on such subjects as *Counseling in Family Relationships, Church and Family Working with Teen-Agers, Materials for the Family Life Program, Selection and Training of Leaders for the Family Life Program.* Mr. Roy E. Dickerson, executive secretary, Cincinnati Social Hygiene Society, was resource leader of the latter group.

A number of recommendations were made to the conference by the section groups: that the American Association of Theological Schools include a course in marriage and family life in its pre-theo-

logical curriculum, that municipal and state councils of churches be encouraged to provide at least one staff member to train leaders in family life education, that a "national workshop" be set up to demonstrate techniques in personal counseling, and that clergymen be better acquainted with the "solid results" of sociological studies of marriage and the family.

United Council of Church Women Holds Fourth Biennial Assembly.—Representing eighty-four Protestant denominations, the United Council of Church Women, meeting in Milwaukee, Wisconsin, November 15–18 for its fourth biennial assembly, unanimously adopted resolutions calling for immediate abolition of segregation and discrimination in the armed forces, endorsing Federal aid to education and urging a broadening of social security legislation. The delegates also approved a joint resolution presented by the Council's Department of Christian Social Relations and Department of Christian World Relations, urging church women to familiarize themselves with the International Bill of Rights.

Mrs. Harper Sibley of Rochester, New York, member, ASHA Board of Directors, was re-elected president of the Council and Miss Gertrude Vint of New York City was re-elected treasurer. Mrs. John M. Hanna, Dallas, Texas, and Mrs. Davis Jorgenson, Altadena, California, were elected vice-presidents and the following five were re-elected:

Mrs. David D. Jones, Greensboro, North Carolina; Mrs. Charles Gilkey, Yarmouth, Massachusetts; Mrs. Wilson Compton, Pullman, Washington; Mrs. J. Quinter Miller, New York, and Mrs. A. H. Sterne, Atlanta, Georgia. The new recording secretary is Mrs. Abbie Clement Jackson, Louisville, Kentucky. Mrs. W. Murdoch MacLeod, Atlanta, Georgia, is the newly appointed executive secretary, succeeding Mrs. Ruth Mougey Worrell who retired recently. Council headquarters are located at 156 Fifth Avenue, New York City.

National Society for the Prevention of Blindness Reports.—The annual meeting of the Society, held December 9 in New York City, marked the completion of forty years of service to the American people through scientific research into the causes of blindness and through the education of the public as to measures to save sight. At the same time, the Society released the first of a series of booklets, as part of the 40th anniversary celebration which will culminate in March 1949 with a three-day international conference in New York on the theme, *The Battle Against Blindness—the Next Forty Years.*

"Much has been achieved during the first forty years," said Dr. Franklin M. Foote, NSPB executive director, in his annual report, "but during the next forty years the battle will perhaps be even harder, for our modern civilization is continually putting new strains on our eyesight." Chairman of the annual meeting was Mason H. Bigelow, Society president.

W. W. Bauer, M.D., Director, Bureau of Health Education, American Medical Association, and Walter E. Hager, president, Wilson Teachers College, Washington, D. C., were elected as new board members. The following seven members

were re-elected: Eugene M. Geddes, New York; Robert F. Irwin, Jr., president, Philadelphia Committee for Prevention of Blindness; R. Townley Paton, M.D., ophthalmologist, New York; Carl E. Rice, M.D., Medical Officer in charge of U. S. Public Health Service Dispensary, Washington, D. C.; W. F. Snow, M.D., chairman, ASHA Board of Directors, New York; Frank H. Woods, Jr., president, Illinois Society for Prevention of Blindness, Chicago, and William Ziegler, Jr., president, American Foundation for the Blind, New York.

National Committee for Mental Hygiene Holds 39th Annual Meeting.—Seven hundred and fifty leaders in the field of mental hygiene, meeting in New York, November 3–5, for the National Committee's 39th annual meeting, heard papers by psychiatrists, anthropologists, state hospital directors, a public health director and psychiatric social workers and also witnessed presentation of the $1,000 Lasker Award for 1948 to Dr. C. Anderson Aldrich. Dr. George Baehr, president of the New York Academy of Medicine, in presenting the award to Dr. Aldrich, who is director of the Rochester Child Health Institute of the Mayo Clinic, Rochester, Minnesota, described the field of pediatrics as "the most forward-looking branch of medicine, one which has assumed its share of preventive psychiatry as no other branch of medicine has done."

Dr. George S. Stevenson, M.D., NCMH Medical Director, in his annual report, stressed the need for wider citizen participation for mental health improvement, stating that a goal of one million members of local or national groups, or one for every psychotic person, is not unreasonable. Dr. Stevenson set forth as immediate objectives a four-fold program of (1) enlistment of more leaders and workers, (2) a wider program of public education, (3) improved services for the treatment of mental illness and (4) prevention of mental illness. The Committee's research and international programs are also of paramount importance.

The National Committee's drive to focus nationwide attention on the urgent need for the prevention and treatment of mental illness is backed by such national leaders as General Dwight D. Eisenhower, Federal Security Administrator Oscar R. Ewing, USPHS Surgeon General Leonard A. Scheele and Dr. William C. Menninger, president of the American Psychiatric Association. Dr. Scheele has said, "In the twentieth century, mental health has become the first health need, the most longed for health goal."

All NCMH officers who served during 1948–49 were re-elected. They are as follows:

President, Arthur H. Ruggles, M.D.; vice-presidents, James R. Angell, LL.D., William L. Russell, M.D., Leonard G. Rowntree, M.D., Frank Fremont-Smith, M.D.; secretary, Mrs. Albert D. Lasker; treasurer, A. L. van Ameringen. Dr. Ruggles serves as chairman of the Board of Directors.

NEWS FROM THE STATES AND COMMUNITIES

ESTHER EMERSON SWEENEY

Director, Division of Public Information and Extension, American Social Hygiene Association

Alabama: Birmingham Social Hygiene Association Formed.—A new society and ASHA affiliate, the Birmingham Social Hygiene Association, came into being toward the end of November when a constitution and by-laws were adopted, officers elected and staff employed. Headquarters are at 1912 8th Avenue South in Birmingham's new Public Health Building. Mrs. John T. Batten has been employed as executive secretary.

Mervin A. Blach, vice-president of J. Blach & Sons, 1928 3rd Avenue North, was elected president; Henry P. Johnston, general manager, radio station WSGN, vice-president; Arthur Crowder, Jr., manager Prudential Insurance Company, 607 Comer Building, treasurer. The Rev. Henry M. Edmonds, D.D., has joined the staff as Consultant on Family Relations and it is planned to employ a full time staff member to work with Negro groups within the next few weeks.

John K. Williams, director, Bureau of Health Education, Jefferson County Board of Health and a former ASHA field representative, was largely instrumental in promoting the organization of this society. Many other Birmingham residents, in addition to the new Association's officers and staff, also cooperated.

Connecticut: YMCA Secretaries Hear Talks on Sex Education.—Two sessions of the monthly meeting of YMCA Secretaries, held in New Haven, December 2, considered the subject of sex education. At a meeting of 25 Boys' Work Secretaries Miss Ann Madsen, Assistant Director, ASHA Division of Public Information and Extension, discussed *Sex Education as a Function of YMCA Boys' Work*, emphasizing the unique opportunity of YMCA's, as leadership groups in many communities, to train workers for individual and group counseling in sex education and particularly for young men contemplating marriage. At a general luncheon meeting, attended by General Secretaries as well as Boys' Work Secretaries, Miss Madsen spoke on *Sex Education, A Function of the Y*.

Indiana: Indianapolis Society Co-Sponsors Meetings at Social Work Conference.—At the 1948 Indiana State Social Work Conference, held in Indianapolis November 3–6, with a theme of *Indiana Today and Tomorrow*, a study course and two meetings of the Health Activities Division were co-sponsored by the Indianapolis Social Hygiene Association, with Mrs. Meredith Nicholson, ISHA executive secretary, as chairman. Dr. John W. Ferree, Associate Director, National Health Council, New York, and Dr. James K. Shafer,

VD Consultant, U. S. Public Health Service, speakers at the two meetings, were heard by about 150 persons, the audiences mainly consisting of social workers, board members of social and health agencies, health workers and educators.

Dr. Ferree, a native of Indiana and former State Health Officer, speaking on *Public Health in Indiana*, discussed the need for local health councils and their function. Dr. Shafer, taking as a topic, *Modern Trends in the Control of VD*, and declaring that, in his opinion, the "miraculous" new treatment methods have led to apathy on the part of the public toward the problem, called for increased citizen interest and participation. He also spoke of the fact that the bulk of present infections are in the teen-age group and stressed the social hygiene point of view that secure and happy early family life and sex education are among the most effective weapons in conquering the venereal diseases.

The well-attended study course on *Emotional Aspects of Illness*, also co-sponsored by the ISHA, was led by Miss Eleanor Cockrill of the Menninger Clinic, Topeka, Kansas.

Later in November the ISHA made news again when Mrs. Nicholson gave a talk on sex education before a PTA study group which was later reported in the Indiana *Star*. This was a meeting in the five-part study course now being given by the PTA.

Maine: Dr. Coombs, First State Health Director, Dies.—Dr. George H. Coombs, ASHA friend and member for almost twenty-five years, died November 20 in Waldoboro, Maine, at the age of 85. For more than sixty years of his life he practiced medicine and was Maine's first health director, assuming that post in 1932 and serving until 1939 when he resigned. A native of Brunswick, Maine, Dr. Coombs was educated at New York University and Bellevue Hospital in New York. Last year he was hailed on the *Vox Pop* radio program as a typical American country doctor.

Maryland Conducts VD Educational Campaign on Eastern Shore.—Dr. Robert H. Riley, State Health Department Director, has announced a special educational campaign against venereal diseases as part of a long-term effort to bring VD rates down in Maryland's nine Eastern Shore counties. The campaign was launched October 1 under the direction of Dr. C. E. Waller, State VD Control Officer, and with the cooperation of county health officers. The aim is to educate every adult in this rural, agricultural area on VD facts, as well as to find and treat victims of syphilis and gonorrhea. On January 1 a similar project will be started in five counties on the Western Shore of the bay. "Campaign results from these two areas," Dr. Riley says, "may be significant in the fight against venereal disease all over the State, and perhaps in other parts of the country."

Radio and special group meetings have been found the best means for reaching the potentially high incidence groups, according to

Dr. Waller. Records on VD are played and VD films are shown at the group meetings. Free literature is available. By means of radio and newspaper publicity in the 35 county weeklies the campaign has received further wide publicity. Newspapers have emphasized: "Syphilis is licked from the medical standpoint; now here is what you must know to finish the job." Broadcasts, scheduled at different times throughout the day to reach a larger listening audience, have used the dramatic-documentary broadcasts prepared by the American Broadcasting Company staff, in consultation with the U. S. Public Health Service and the School of Public Health of Columbia University.

Studies made previous to the educational undertaking showed syphilis ranking first in 1947 among all communicable diseases reported from Maryland's 23 counties, with gonorrhea ranking second. Together they accounted for 37 per cent of the communicable diseases reported. Blood tests of the first two million army selectees in 1941 showed Maryland as one of the group of states with the country's second highest venereal disease concentration.

While results from the educational campaign are not yet available, Dr. Waller states that the long-term drive in the Eastern Shore area has shown a 67 per cent increase in the number of previously unfound cases of infectious syphilis brought to health clinics for the quarter July–September as compared with the previous three months. General VD clinic attendance on the Shore rose about 35 per cent in the same period.

Michigan Undertakes Research in VD Case-Finding.—Dr. John A. Cowan, Director, Michigan VD Control Bureau, has announced the undertaking of a research study with the primary object of finding out what is wrong with current case-finding methods and to ascertain why interviewing for contacts so often yields poor returns. This study, *Syphilis Case-finding by Epidemiologic Methods*, sponsored by the Michigan Health Department and the U. S. Public Health Service, is so set up that within twenty-four hours after a VD patient has been interviewed at the Michigan Rapid Treatment Center at Ann Arbor or the Detroit Social Hygiene Clinic special investigators in major cities of the state can begin tracing contacts. Through rapid telephone relay of information investigators will take immediate steps to see that contacts go to a physician or clinic for examination.

The study got under way November 1 and will continue through June 30, 1949.

WORLD NEWS AND VIEWS

JEAN B. PINNEY and JOSEPHINE V. TULLER
Director *Assistant Director*

LIAISON OFFICE FOR INTERNATIONAL SOCIAL HYGIENE AGENCIES AND ACTIVITIES

International Union against the Venereal Diseases: Notes on the 1948 General Assembly.—As announced in previous issues of the JOURNAL, the Union's 1948 General Assembly—its 25th Anniversary Meeting—was held in Copenhagen, Denmark, September 6–10, the Danish Government and the Danish Society for Combating Venereal Diseases being hosts. Seventeen nations sent delegations, with many other countries whose delegates could not attend sending letters, reports and papers. Among those present were:

DELEGATES TO THE 1948 GENERAL ASSEMBLY

Representing National Member Agencies and Programs

AUSTRIA
PROFESSOR LEOPOLD ARZT, Ministry of Social Affairs, Public Health Section

BELGIUM
DR. LEON DEKEYSER, President, National Belgian League against Venereal Diseases; Vice President IUVD
DR. P. VAN DE CALSEYDE, Director-General, Ministry of Public Health and of the Family

BRAZIL
DR. HENRI DE MOURA COSTA, Director, Gaffree Guinle Foundation
DR. LUIS CAMPOS MELLO, Chief, Venereal Disease Division, Ministry of the National Department of Public Health

BULGARIA
DR. BOYADJIEV, Bulgarian Society of Dermatology

DENMARK
DR. H. BRUN-PEDERSEN, President, Danish Association against Venereal Diseases; Assistant Secretary-General IUVD
DR. AXEL PERDRUP, Chief Assistant, Rudolph Bergs Hospital for Skin and Venereal Diseases
PROFESSOR AXTHAUSEN
DR. KRISTJANSEN
DR. HAROLD BOAS
DR. POUL V. MARCUSSEN, Chief Physician, Department of Dermatology and Venereology, Copenhagen Municipal Hospital
DR. REYNAUD

FINLAND
DR. TAUNO PUTKONEN, Vice-President, Finnish League against Venereal Diseases
DR. YRJO SALMINEN, Secretary, Finnish League against Venereal Diseases

FRANCE
DR. ANDRÉ CAVAILLON, Director-General, Ministry of Public Health; Secretary-General IUVD
PROFESSOR L. M. PAUTRIER, Ministry of Public Health
DR. DUREL, Ministry of Public Health
DR. LAVOINE, Chief, Venereal Disease Division, Ministry of Public Health
DR. H. SAUTTER, Chief, Cabinet of the Director General, Ministry of Public Health
MISS MARGUERITE TROUÉ, Administrative Secretary IUVD

GREAT BRITAIN
- Dr. Mary Michael Shaw, Venereal Disease Division, Ministry of Health
- Dr. Robert Forgan, Central Council for Health Education
- Mrs. Sybil Neville-Rolfe, Vice-President IUVD

ITALY
- Professor Franco Flarer, President, Italian Society of Dermatology and Syphilology

MEXICO
- Dr. Jaime Velarde Thomé, Chief, Venereal Disease Control, National Department of Health

MOROCCO
- Dr. Lepinay, Technical Counselor, Moroccan Society for Prophylaxis of Venereal Diseases, Ministry of Public Health
- Dr. G. Sicault, Director of Public Health and the Family

NETHERLANDS
- Dr. E. H. Hermans, President, Netherlands Union against Venereal Diseases; Vice-President IUVD
- Professor J. J. Zoon, President, Netherlands Society of Dermatology
- Dr. H. M. L. Sark, Treasurer, Netherlands Union against Venereal Diseases

POLAND
- Dr. T. Stepniewski, Treasurer, Polish Union against Venereal Diseases
- Dr. J. Suchanek, Chief, Venereal Disease Division, Ministry of Health
- Professor F. Walter, Vice-President, Polish Antivenereal Association

PORTUGAL
- Dr. Tovar de Lemos, Director, Social Hygiene Dispensary of Lisbon

SWEDEN
- Professor Sven Hellerstrom, Professor of Dermatology and Venereology, Caroline Institute
- Dr. Malcolm Tottie, Public Hygiene Office of Sweden
- Dr. Brandt

SWITZERLAND
- Professor Walter Burckhardt, President, Swiss Society against Venereal Diseases

UNITED STATES
- Dr. William F. Snow, President, IUVD; Chairman, Board of Directors, American Social Hygiene Association
- Dr. Joseph S. Spoto, Assistant Chief, Venereal Disease Division, US Public Health Service
- Mr. Bernard H. Flurscheim, Treasurer, IUVD
- Mrs. Robert N. Tuller, Assistant Director, Liaison Office for International Social Hygiene Agencies and Activities, American Social Hygiene Association
- Professor C. M. Hasselmann, Adviser from Land Bavaria to US Delegation to IUVD General Assembly

Representing International "Technical Counselor" Agencies

INTERNATIONAL COUNCIL OF WOMEN
- Dr. Agnete Boestrup

LEAGUE OF RED CROSS SOCIETIES
- Dr. Z. S. Hantchef, Director, Bureau of Hygiene

UNITED NATIONS WORLD HEALTH ORGANIZATION
- Dr. Thorsteinn Guthe, Medical Officer, Venereal Diseases

Also in attendance were Dr. Madsen, former Director and Dr. Holm, present Director of the Serological Institute of Copenhagen, and other international authorities whose participation and advice were of great value to the delegates.

Proceedings of the 1948 Assembly

Resolutions adopted at the 1946 and 1947 General Assemblies in Paris, and activities undertaken subsequently were discussed at the 1948 Assembly together with reports and recommendations of Committees; and plans were made fulfilling the Union's responsibilities, as the International non-governmental agency in its field, including cooperation with the World Health Organization in a world-wide attack on the venereal diseases.* In this connection Dr. Guthe's advice as an "observer" was extremely valuable.

Among the subjects and problems of special interest were the reports of the Union's three special committees appointed in 1947, as adopted at their meetings at The Hague, Holland, in March, 1948.

Committee No. 1. Dr. Hermans, Chairman, on *Revision of the Brussels Agreement on Venereal Disease Treatment for Seamen.* The Assembly approved the Committee's recommendation that this Agreement should be revised and extended to protect land migrating groups, such as industrial workers and farm laborers and boatmen employed in river traffic, who frequently cross national borders for temporary employment. (See below: Rhine River study.) It was suggested that a technical commission might make on-the-spot examinations in certain ports and areas to determine the best ways and means of practical application of the Agreement.

Committee No. 2. Dr. Van de Calseyde, *Chairman*, on *Cooperation with the World Health Organization.* The Assembly approved the Committee's review of cooperation extended during the two years of effort by the WHO Interim Commission, commended WHO plans for concentrating its VD campaign upon eradication of syphilis as a menace to maternal and child health, and offered full cooperation and support of the Union in such efforts.

Committee No. 3. Mrs. Neville-Rolfe, *Chairman*, on *Psychological and Biological Aspects of the Venereal Disease Problem.* The Assembly received the progress report and approved the continuance of the Committee and its studies of these problems, with the understanding that a further report would be submitted for consideration at the next Assembly session.

Another interesting section of the Assembly program centered around *Modern Treatment of Syphilis*, those taking part including: Professor P. Popchristov, Dr. G. Gheorghiev, and Dr. M. Levcoff, of the University Clinic for Cutaneous and Venereal Diseases of Sofia, Bulgaria; Professor Degos, Dr. Sicault, Dr. Lepinay, Professor

* As announced in the December Journal (page 443) WHO's Executive Board, meeting in Geneva, on November 2, approved the Union for "official relationship," following recommendations by the WHO Expert Committee on VD, and the WHO Committee on Non-governmental Organizations.

Hellerstrom and Dr. Spoto. The following resolution later adopted by the Assembly regarding the present status of syphilis therapy expressed the conclusions reached by the discussants:

"The International Union against the Venereal Diseases recognizes the great therapeutic value of penicillin in syphilis and recommends this treatment, whether or not associated with other anti-syphilitic drugs, for the treatment of pregnant women and infants.

Pending the time when sufficient penicillin can be produced to meet the entire need of the anti-venereal campaign, the Union hopes that the World Health Organization will continue to make it available especially for the treatment of prenatal and congenital syphilis.

The Union considers that the classic treatments by arsenic and bismuth continue to have value, and should be used when indicated.

With regard to the therapeutic action of bismuth, the Union emphasizes its usefulness in all cases of contagious syphilis and prenatal infections, as a powerful weapon against the spirochete.

The Union, in view of the varying experience among the countries with regard to accidents resulting from arsenic treatment, recommends study of that question, and of ways and means of treating such accidents, particularly with BAL."

Public health methods and progress in prevention and control of venereal diseases furnished another topic of much interest. In this connection Professor Pautrier and Dr. Hermans presented a report on the Union's study, begun before the War, of the transmission of VD among river boatmen in the Rhine District. A resolution was adopted by the Assembly calling for further study of the prevalence of VD among boatmen and the general population in the vicinity of large rivers where boat traffic is heavy. It was suggested that the Union might cooperate with the WHO in promoting extension of the Brussels Agreement to cover such workers and populations.

Dr. Spoto contributed a paper on *International Contact Investigation*, and Dr. Velarde described the *International VD Campaign on the US-Mexican Border*.* Both these subjects were of special interest and discussion during the meetings. Mr. Bernard H. Flurscheim, who recently completed a year's travel among South and Central American countries and in the Caribbean Area, spoke of social hygiene conditions and needs and the opportunity presented for the Union to aid all these nations to develop strong national and regional non-governmental member agencies to assist their respective governmental programs.

* This paper, presented in French and English at the Assembly, and included in the Proceedings in French, also appeared in Spanish in the October issue of the Bulletin of the Pan American Sanitary Bureau, Washington. (*La Oficina Sanitaria Panamericana y la campana antivenerea internacional en la frontera a Mexico-Estadounidense* by Dr. Jaime Velarde Thomé).

The Assembly received with interest a report prepared by Miss Jean B. Pinney as Director of the Union's Regional Office for the Americas on its work during the past year. A resolution was adopted warmly approving the report and thanking the American Social Hygiene Association for its generous contribution of personnel and operating expenses for this project, now in its third year. The Assembly also voted to ask the Association, as a special world service, to continue its operation of this Regional Office in 1949, and also to continue to represent the Union in its relations with the United Nations Officers and staffs at the UN World Headquarters at Lake Success and in New York.

Other Plans for the Future

In addition to the resolutions adopted and other actions taken by the Assembly as reported above, the following should be noted with regard to the program for 1949 and subsequent years:

Future General Assemblies

The Union has received an invitation from Italy to hold the 1949 Assembly in that country. This proposal was favorably viewed by the delegates attending the Copenhagen meetings, and was referred to the Executive Committee for final consideration in connection with previous invitations still pending.

The Secretary-General was asked to explore the possibility of arranging for the 1950 General Assembly to be held at the time and place chosen for the next International Congress on Dermatology, tentatively scheduled for a city in the United States.

Program of the 1949 Assembly

The delegates concurred in suggesting to the Executive Committee that consideration be given at the next Assembly to inclusion of the following subjects:

1. Extent and causes of accidents from arsenical therapy.
2. Heredity in relation to problems of syphilis control.
3. Problems of prostitution and related social measures.

Program for Public Education

The Secretary-General was instructed to promote a study of programs for public education regarding the venereal diseases and the citizen's part in their eradication.

Election of Officers

The Union's officers are elected for three-year terms, and those chosen in 1947 at the first postwar General Assembly therefore continue to hold office in 1949. They are:

President: Dr. William F. Snow, United States of America.

Vice-presidents: Mrs. Sybil Neville-Rolfe, Great Britain; Dr. Edward H. Hermans, Holland; Dr. Leon DeKeyser, Belgium; Prof. Karel Gawalowski, Czechoslovakia.

Technical Counselors: Prof. Marian Grzybowski, Poland; Colonel L. W. Harrison, Great Britain; Prof. Henri Gougerot, France; Dr. M. Martinez Baez,

THE AMERICAN SOCIAL HYGIENE ASSOCIATION

organized in 1913, is the national voluntary agency for social hygiene.

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CONTENTS OF RECENT ISSUES

MAY, 1948

Recent Developments in Army and Civilian Health Programs

Editorial: Soldiers Are People.....Walter Clarke, M.D.
Social Hygiene at the Universal Military Training Experimental Unit.....Maj. Gen. John M. Devine
Venereal Disease Control in the First Army Area.....Capt. George J. Carroll
Penicillin in the Venereal Disease Control Program.....Thomas B. Turner, M.D.

JUNE, 1948

Fifteenth Annual Library Number

Editorial: A Generation of Library-Social Hygiene Cooperation
Education for Personal and Family Living as Applied to the Social Hygiene Field. A Preliminary Report....Jacob A. Goldberg, Editor
Book Reviews
Books of General Interest
Books on Sex Education, Marriage and Human Relations
Books on Health Education
Books on Legal and Social Protection
Books on Medical and Public Health Activities

OCTOBER, 1948

Community Service Number

Editorial: Social Hygiene and the Red Feather
We're at Your Service.....Philip R. Mather
Some Social Hygiene Problems of Los Angeles County.....Walter Clarke, M.D.
Four GI Student Families Tell Their Stories....Howard and Sylvia Bahar Ennes

NOVEMBER, 1948

Progress in State Legislation to Guard Family Life from the Venereal Diseases

Editorial: Premarital and Prenatal Examination Laws in Review
Progress in State Legislation to Protect Marriage from Syphilis (Maps)
State Premarital Examination Laws: Legislative Requirements . . . Legal References . . . Dates of Approval . . . Effective Dates . . . Legal Waiting Period in Relation to Marriage License
Progress in State Legislation to Protect Babies from Syphilis (Maps)
State Prenatal Examination Laws: Legislative Requirements . . . Dates of Approval . . . Effective Dates . . . Legal References

DECEMBER, 1948

Social Hygiene Day Number

Editorial: The Theme and the Slogan for Social Hygiene Day 1949.....Charles Walter Clarke, M.D.
The Challenge and the Opportunity Before Our Field Workers.....Orel J. Myers
Past, Present and Future Responsibilities of Social Hygiene Societies in the Control of the Venereal Diseases.....R. A. Vonderlehr, M.D.
Sex Education—One Phase of Human Relations.....Lillian B. Davis
Washington Fights Gonorrhea—A Preliminary Report.....Jean B. Pinney